Mental Health Medication Advisory Committee Meeting Meeting Minutes, Open Session May 9, 2017 at 2 pm – 4:30 pm		
MHMAC Open Session HP Enterprise Services Capital Room 6511 SE Forbes Ave, Topeka, KS 66619	**Members Present:** Susan Mosier, Secretary of KDHE, MD, MBA, FACS (Chair) Vishal Adma, MD, MS, CMQ, CPE Holly Cobb, NP Nicole Ellermeier, PharmD Brad Grinage, MD Rebecca Klingler, MD Charles Millhuff, DO Karen Moeller, PharmD, BCPP Taylor Porter, MD **Members Absent:** None **KDHE Staff Present:** Ashley Goss, Interim Deputy Secretary of KDHE/ Appointed Temporary MHMAC Chair Annette Grant, RPh, KDHE/DHCF Carol Arace, KDHE/DHCF **MCO Representatives Present:** Jennifer Murff, RPh – United Healthcare William Mack, MD – Amerigroup Lisa Todd, RPh, BBA – Amerigroup Angie Zhou, Pharm. D. – Sunflower Katherine Friedebach, MD – Sunflower Sosunmolu Shoyinka, MD – Sunflower **HP/HID Staff Present:** Nancy Perry, RN Karen Kluczykowski, RPh Ariane Casey, Pharm. D. (phone)	**Representatives:** Matt Keith, KDHE; Rick Keglen, Otsuka; Jody Legg, Alkermes; Roy Lindfield, Sunvion; Susan Moeller, KDHE; Lucy Wang, KDEX; Amy Capbell, KMHC; L. Tygen,

	DISCUSSION	DECISION AND/OR ACTION
I. Call to Order A. Introductions B. Announcements	**Call to Order:** Dr. Mosier: We are working out some technical details so if you hear a little bit of feedback… Can you hear me better? I'm going to check with the audience back here. Can you hear? Good. Good. I will ask that people when we are talking today we do have microphones placed around so that everyone can hear the discussion. It is a little better this time because we have a smaller room but it will help a lot if you would utilize the microphones. **Introductions:** Dr. Mosier: I think what we want to do first is a round of introductions around the table here. I will start I am Susan Mosier Secretary of the Department of Health & Environment also the State Health Officer for Kansas and the chair of the committee. I will go this direction. Ms. Grant: I am Annette Grant; I am the Pharmacy Program Manager. [Dr: Mosier: Microphone, microphone.] He said if we used that one it would cause static in that one so we can't use this one. Dr. Mosier: What if I turn this off? Ms. Grant: Okay, then we could. Yes. Dr. Ellermeier: Nicole Ellermeier, pharmacist. Dr. Todd: No I am not going to sing karaoke… that comes later. My name is Lisa Todd; I am the pharmacy director for Amerigroup. Dr. Murff: Hi, I'm Jennifer Murff and I am the pharmacy director for United Healthcare. Dr. Porter: Hi; Taylor Porter; I am a psychiatrist. I am currently working at a facility called Katie's Way but I am representing the mental health center directors and have maintained a presence in their organization. Dr. Grinage: Hi, my name is Brad Grinage, I have a private forensic practice but also I work with the VA with my representation of the Kansas Psychiatric Society.	Sec. Mosier called the May 9, 2017 MHMAC meeting to order at 2:00pm.

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	Dr. Klingler: I'm Becky Klingler. I am a pediatrician in Manhattan. Dr. Millhuff: Hi, Chip Millhuff; child psychiatrist here in Topeka. I am at family service and guidance center. Dr. Moeller: Karen Mueller; I am a pharmacist at KU Medical Center and also teach at the school of pharmacy. Dr. Zhou: Angie Zhou for Sunflower Health plan. Ms. Arace: Carol Arace; KDHE Division of Healthcare Finance Administrative Assistant. Dr. Adma: Vishal Adma. Psychiatrist. My background: Medical Director for KVC Hospitals and a member of the Kansas Psychiatric Society. Ms. Goss: Ashley Goss, KDHE, Deputy Secretary for public health. **Announcements:** Dr. Mosier: For today we are going to go through the old business; the prior authorization criteria from last time after we go through the minutes and then we have new business of the Benzodiazepine Dosing Limits. We also will if we have time go through some prior authorization forms that should greatly simplify the efforts there, so we want to present what we've got to date on that.	
II. Old Business A. Review and Approval of February 14, 2017 Meeting Minutes	Dr. Mosier: First, is the review and approval of the February 14th meeting minutes; so I will just open it up if there is anyone that has any additions, corrections, to the meeting minutes? **Committee Discussion:** Dr. Adma: Do you need a motion to approve? Dr. Mosier: I need a motion please.	Dr. Adma moved to approve the minutes as written. Dr. Porter seconded the motion. The February 14, 2017 MHMAC meeting minutes

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	Dr. Adma: Motion to approve. Dr. Porter: Second. Dr. Mosier: it has been moved and seconded that we have accept the meeting minutes for the February 14th meeting. All in favor say 'Aye'? {Several 'Ayes' are heard} Dr. Mosier: Any opposed? {Silence} Dr. Mosier: Thank you. The meeting minutes have been approved.	were approved as written unanimously.
II. Old Business B. Prior Authorization Criteria 1. Antipsychotic Dosing Limits in Children less than 16yo	**Clinical Public Comment: -** No requests were received. Dr. Mosier: We are going to move on first to the anti-psychotic dosing limits in children less than 16 years of age and I will turn this over to Annette to walk through any of the changes that were made since the last meeting. There were multiple discussions that went on via e-mail to help get us to this point. Ms. Grant: Alright so what we did is we tried to be consistent with the requires PA versus FDA approved; FDA not approved. Trying to be consistent for all the age groups to say the same thing. So we have updated that Then there were some suggestions to take out Chlorpromazine and so I do have to… there were some patients that were on… There were some patients that were on it and so I thought I would leave that for some discussion. I think there were some psychiatrists that were still using it so do we want to still leave that in there as an option or take it out? **Committee Discussion:** Dr. Porter: Was it the Chlorpromazine or the Compazine? Dr. Moeller: It was Compazine. Ms. Grant: I apologize, it was Compazine, yes, thank you so much. And actually I did take that out.	***First Motion:*** Dr. Porter made the motion to change Fluphenazine, Haldol Deaconate, Sustenna, Trinza, Consta, Abilify Maintena, and Aristada in the 4 to 6 year old column from 'Requires PA' to 'Not Approved'. The motion carried unanimously by show of hand in approval. ***Second Motion:*** Dr. Porter made the

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	So just bringing that back to you that we did take that out. I apologize. I think those were the main things that were… the comment again is can we have starting doses for Aripiprazole and from last we learned from the systems approach we could not do both a max starting dose and a max daily dose. So we had decided to go just with the maximum daily dose and no max starting dose. Dr. Moeller: I did have one comment when I was looking over today just again on the long-acting injections like the Paliperidone; like the Invega Sustenna; I think we really should say like not approved for that for like less than 6 and probably the PA I thought was really just for the 10 through 16 year old age range. That was, I can't imagine giving a long-acting injection ever for less than six and let's say 6 to 10. They just don't have formulations that I think probably can safely give. Ms. Grant: So not approved for the younger one's but then 10 on up requires PA? Dr. Moeller: Yes. Ms. Grant: Okay. Dr. Moeller: That was the only thing that I noticed. That would be for like the Abilify long acting one; and it would also be for the Haloperidol Deaconate and the Fluphenazine Deaconate. Dr. Adma: It's interesting that oral Invega is not approved. Dr. Porter: There may be still a language thing if I might. I think not approved we are still saying not FDA approved. That's what that means and then PA required would be a higher step because some things that are not FDA approved we are not requiring a PA for. Am I right in that? And the thing about giving shots to a 4 year old would be almost like non-applicable. It is just not ever going to be ok. Dr. Moeller: I think the one thing I had when we communicated via e-mail we had like several doses for like the 6 to 10 that were, technically, not FDA approved… Dr. Porter: Right.	motion to change the category 6 to 10 to match the change that was made for the 4 to 6. Dr. Ellermeier seconded the motion. The motion carried unanimously. ***Third Motion:*** Dr. Ellermeier made the motion to add the not approved items to the clinical criteria for age. Dr. Moeller seconded the motion. The motion carried unanimously. ***Fourth Motion:*** Dr. Millhuff made the motion to change the title of the criteria by

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	Dr. Moeller: So but then we would have a column on some drugs that say not FDA approved but then we would have dosages for things that were not FDA approved too. Dr. Millhuff: My understanding is that when we put these criteria together that it was not approved by our committee; that is what my impression was. I mean so many of these medicines are not approved by the FDA that is quite common, and so my thought was not approved meant not approved by our committee. I hope that's not making [things] more confusing. Dr. Porter: Sorry, you guys have worked… By the way just you guys have worked very hard outside of this meeting on this… I'm sorry for not hashing this out with you before now; I should have taken advantage of that. So we're not… on some of these we're just not … we are going to say you can't have this? But when it says not approved on here, we're just, no matter if you do a PA or not, we are not allowing it? Dr. Millhuff: That is my input; I don't know if others agree with that. Dr. Porter: Ok, then that is different than how I was reading this; thank you. Dr. Ellermeier: I think that's what is distinguished between the not approved and requires PA because that requires PA could still mean like there's not necessarily something that is approved for that age range but we think it is probably more appropriate. Dr. Porter: I see; thank you that is different than what I said. Dr. Millhuff: I had also raised the question though that as time goes on… some of these, our data will grow in terms of evidence for safety and effectiveness and it is just a comment to say just down the road we might want to review these lists and update them. Dr. Adma: The other thing is do we really want to complicate it by saying not approved and PA because even for people who sit on their side if you have to many of these they will get confused or do we just go with whatever we recommend and whatever requires a PA? Dr. Zhou: If I could just add on to what Dr. Adma was saying; operationally we would like to have you to tell us what you want us to do when it says not approved. Do you want us to not have a PA	adding 'children and adolescents'. Dr. Moeller seconded the motion. The motion carried unanimously.

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	approved for the drug for the kid or do you just want us to not approve the dose because this is a dosing PA so it gets a little bit vague when you are getting the drug into it as well because we have a whole separate PA for drugs; for anti-psychotics. Dr. Adma: So this is only a dosing PA? Dr. Zhou: From what I can tell this is only a dosing PA; yes. Ms. Grant: Yes. Dr. Adma: So what you need on this table is only requires PA and a dose? Dr. Zhou: I think we just need prior definition of what you want us to do when we do receive a PA request for the drug and it says not approved in this box. Do you want us to not approve it period if the child is between that age or what do you want us to do with that drug? Dr. Moeller: That was my understanding. So, yes, any dose for Abilify Maintena would be not approved. Dr. Zhou: Okay. Dr. Moeller: For less than 6. Dr. Zhou: I think we just need to have a very clear definition on what 'not approved' means. Dr. Porter: What do we have the Haldol, nevermind, my mistake. Delete that. Dr. Adma: For example, in this file it says Saphris not approved. So, as Chip said with time things might change right? So, we would say, you know, we don't want to say not approved but… Dr. Porter: Where it says 'not approved', there's no appeal process? Dr. Adma: Right. I think that's what Karen…	

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	Dr. Friedebach: You would still have an appeals process. You could submit documentation. It would just they would use this criteria to then… Dr. Mosier: We are going to use microphones so everyone around the room can hear so we are passing it down. Dr. Friedebach: Sure. You're asserting that it shouldn't be approved in this age group but it wouldn't change their appeals process. The provider would still have an appeals process that they can submit documentation and so and they would still have a peer-to-peer process in place too. Your criteria does not change the process by which you can get approval it's just giving the reviewers the support to say that this committee and that the State of Kansas believes that this is the way the criteria should be followed. Dr. Grinage: With extraordinary circumstances that reviewer could be safe for this? Dr. Friedebach: Yes, I mean that's typical for all managed care companies, and I don't want to speak to... Dr. Mack you might be able to give your perspective too; but when an appeal comes in, as a clinician, I am going to look at everything you submit and I'm going to decide if there is an extenuating circumstance and then I have that option. This just kind of gives a framework by which we would say no we're going to deny based on this direction and I don't know if you have more… Dr. Mack: I hate to waste all the time with the microphone, but basically what you said, but no, that's pretty much it. We just use these as guidelines I mean there are always circumstances where we're going to use it as a guidelines not an absolute rule and once we receive the info from the provider if it makes good clinical sense to go around the guideline and approve it that is what we are going to do. These are often times overturned when we do the appeal if it makes good clinical sense. Dr. Todd: So then my other question kind of back to Angie's operational, so my question if we say not approved here on the dosing PA then what happens to our clinical PA for anti-psychotics for children ages 6 and younger? Do we need to amend that criteria? Because if the member's approved for this criteria then are we are just saying we are not setting a dosing limit if it's not approved, or do you know what I mean, its two separate criteria so… I just need to know how to handle that is all.	

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	Dr. Porter: This is just to make sure I'm… me and anybody else who didn't understand is clear on this… We have status called prior authorization required. Prior authorization, in a way, is an appeal… the simplistic thing here. It is requiring additional questioning and explanation. Right, you sending in a form saying why you are doing this and so that will not get confused by the MCO's between the prior authorization and then an appeal process. Dr. Mosier: They're very separate processes and well understood. I think to your question Lisa I think we want to make sure that we are going through and making sure that there's conforming changes; when we make a change here it is consistent across policy. Dr. Todd: Yes. Dr. Adma: I do agree with Karen when she says for kids less than 6 or less we really want to have a not approved for long-acting medications; the injectable forms and there are lots of injectable forms listed here which include all of the things that Karen listed and we can go through one after another. For those columns less than 6 years in my thinking we need to say not approved which means no psychiatrist and/or private physician can prescribe these at all. Number 2 there are other medications listed which are the atypical antipsychotics as well as typical antipsychotics where they say not approved for use and my thinking on that is we need to change that to require PA so there is a process where a psychiatrist and I think that is the same mechanism to be followed that Jennifer and Lisa talked about in terms you know, do we go back and change what we have already approved in terms of lose those anti-psychotics in those group of patients. Those are my thoughts. Ms. Grant: So, Dr. Adma, are you saying that all the ones that say 'not approved' to change those to 'require PA'? Dr. Mosier: We will have discussion; we are not changing we have had a lot of review too so we will have discussion. Dr. Millhuff: I was looking at the Texas guidelines and one of the some of the language they use in there let's say for these 4 to less than 6 would be insufficient evidence so they use basically two phrases; either 'insufficient evidence' or 'not approved' for children and adolescents. Now I will also highlight that in their table they also list what is FDA approved and so when they use not	

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	approved they are specifically saying that when it comes to the FDA this medicine is not approved for these age ranges. So the table in itself becomes kind of an informational piece and for anything outside of that they just say there's not, there's insufficient evidence so I would just suggest that as maybe a different term. Dr. Ellermeier: So what operationally then happens when a patient is trying to use a medication then that there's insufficient evidence is there a PA in place or how does a prescriber or patient get access to that medication I think is what we need to solve for. {Several members at the table say 'yes' or 'right'.} Dr. Moeller: I think… I think that's more… I had that and that's what I use to double check things. I think that is more informational I don't think it is actually the procedural thing. I don't think it says like requires a prior authorization; I remember it would say not FDA approved, insufficient evidence… I don't know if it's procedural. Dr. Ellermeier: Do we want patients to have access to those medications at those ages with a PA or do we want them just to say just not approved and not be able to get those medications without an appeal? Dr. Millhuff: I'll just say I think that they should be available through only an appeal and I mean we… these medicines are very limited in our understanding particularly these very young children and one of things we are guarding against is the idea that adult prescribing partners are going to pressed on young children when there's just simply not enough evidence. If there is an unusual situation where so many things have been tried and it is coming for an appeal and that's been thoroughly reviewed so be it. I mean that… it would be up to the medical director or whoever does these reviews. I'm sorry I just don't know how the process works well enough from the insurance side. Dr. Porter: This is just following up on Dr. Adma's point we probably are going to need to take a motion to change… we do have PA for several injectables in 4 to 6 year olds. And, we, I think we want that to be not approved. Do we want, we will… also need to decide if we want to move the 6 to 10 year olds for the long acting injectables to that same category or keep them as PA.	

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	Dr. Mosier: How about if we entertain them as separate motions. The first one, do you want to go ahead and make that motion? Dr. Porter: The first motion would be just to follow up to operationalize what Dr. Adma said we have I think 5 that show requires PA for a long acting injectable in a 4 to 6 year old. Dr. Adma: Do you want to name them? Dr. Porter: Yes, I've got Fluphenazine, Haldol Deaconate, Paliperidone - or Sustenna I should say, Trinza, and Consta all have requires PA in the 4 to 6 and I think we want that to be not approved. Dr. Adma: Then there is Abilify Maintena and Aristada too, right? Dr. Porter: I didn't… Dr. Ellermeier: Correct. Dr. Adma: On the first page… Dr. Porter: Yes that… on the first… yes, that actually gives a dose. I think that's probably not what we want on the, oh yes, on the Maintena. Yes, you're right I missed those. Dr. Adma: Just add those to the list and then I would probably say I would say let's add Clozaril to that list, too, for 4 to 6 year olds so the list should include the injectables and Clozapine. Dr. Moeller: I guess I'm asking for clarification because we already have Clozapine as not approved; are you asking to change that? Dr. Adma: No, just keep it the same. Dr. Moeller: Okay. Dr. Porter: I guess we could move on that but I think the question about the 6 to 10 year olds is probably another one.	

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	Dr. Mosier: So we have 6 medications in the 4 to 6 year range that we want to change from 'requires PA' to 'not approved'. Dr. Porter: There's 7. Dr. Mosier: Seven. Okay, have you got all 7? So you are moving that we change that and I think we will just go around with a voice vote. In favor say yes, not in favor say no… we can do hands too. That's faster. {All Committee members raise their hand in approval} Dr. Mosier: That passes. Then the next motion or the next area of discussion. Dr. Porter: Or the next discussion would be we are talking about these long acting injectables for 6 to 10 year olds. I'm thinking that would be almost as unlikely but I'll lean on what you guys think. Dr. Moeller: That is what I was requesting at the beginning too. To change that column for 6 to 10 also to be not approved. The only required PA should be the 10 to 16 years of age. Dr. Porter: I make a motion we change the category 6 to 10 to match what we just did for 4 to 6. Dr. Grinage: Does that include Clozapine for the 6 to 10? I don't have as much experience with regards to children. Dr. Mosier: That is a good point. Dr. Grinage: I think this really comes down to the child folks is rather they feel like… I don't know how much that is used in a 10-year-old. Dr. Ellermeier: I think we already had the Clozapine for 4 to 6 as not approved so we didn't change that. Dr. Grinage: Six to 10, they have a dose.	

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	Dr. Ellermeier: Yes. Dr. Adma: Chip, have you ever used Clozapine in a 10-year-old? Dr. Millhuff: Never. Dr. Porter: I hate to just give this much anecdotal information but I do know certain treatment centers have used it for probably way off label. Used to put a lot of the young, really disturbed children on Clozapine. I don't know about 10 but certainly younger. I don't want to lobby for that. I just wanted to throw that out there as something I was aware of. Dr. Grinage: These are probably a small end of outliers. The question is whether it's just a prior auth is appropriate or the appeals process? Dr. Mosier: The appeals process if that, obviously, if that was not approved in that 6 to 10-year range with Clozapine then they would have an appeals process and that would take what length of time? I guess it's probably a matter of what the difference in timeframe would be. Dr. Friedebach: You can do an expedited appeal which is 72 hours. And you can do a peer-to-peer which is even quicker than that. Dr. Millhuff: I put the 300 on there for this age range based on the Texas guidelines and this chart is built from a review of the evidence and they had at their maximum from 8 to 11 years of age up to 300mgs per day. I look to that chart for information to add that to this list. Dr. Grinage: That's good to know. Dr. Millhuff: I've never used it with anyone that age but there must be some evidence for that. At least according to this reference. Dr. Mosier: So in your motion we have the 7 long acting injectables; do we want to add Clozapine for 6 to 10 or not, to this motion? Dr. Grinage: I would feel comfortable modeling after Texas because they researched it. I think	

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	again it still requires PA correct? Dr. Shoyinka: If I could just add to that discussion. There's a workgroup based in Austin and I think, from everything I understand, that's considered a standard of care or at least acceptable. So I would agree with this. Dr. Mosier: I think we are mixing motions, so why don't we consider the first motion of the 7 and then we'll address the second one. To make the conforming changes for the 7 long acting injectables you had the motion on the table. Dr. Porter: For the 6 to 10 year olds. Dr. Mosier: So a second to that motion. Dr. Adma: I actually want to say there's actually 8 not 7. Dr. Mosier: Okay. Dr. Adma: So that's Abilify Maintena, Aristada, Fluphenazine, Haldol Deaconate, Olanzapine Relprevv, Invega Sustenna, Invega Trinza, Risperdal Consta. So that's a total of 8 without Clozapine. Dr. Ellermeier: I think the Olanzapine is already there so that might be confusing; we already have it as not approved. Dr. Adma: Oh, yes. Dr. Ellermeier: But I would second that motion. Dr. Mosier: All in favor –'Aye'. {Several 'Ayes' are heard} Dr. Mosier: Any opposed?	

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	{Silence} Dr. Mosier: That motion passes and we move on to the discussion of any other medications, Clozapine being one, do we want to make any additional medications not approved as opposed to having the maximum dose listed. Dr. Adma: So for Clozapine do we put preauthorization and max dose of 300 in there? Dr. Porter: Right now it doesn't have a PA. Dr. Adma: I know. Do we change that to update it to say requires preauthorization max dose of 300 for that group? Dr. Moeller: What would… Is there specific criteria then that you would have to have for a prior authorization? Dr. Friedebach: Essentially if they met the prior authorization criteria for the atypical anti-psychotic class if they didn't exceed that dose then it would go through. Dr. Adma: It's a dose. Dr. Friedebach: Because you're holding on dose limits essentially. So your prior authorization criteria are in a separate set so this is really going to allow us to put those dose limits on. Dr. Moeller: I think just stay the same. Dr. Todd: Okay, so then I have a question; I understand this is about the dosing limits but we do require this is kind of back to the under 6 and the 6 to 10 we do have clinical PA on these drugs already that it does require PA so I'm a little concerned if we say it's not approved like no dose is approved for these children then we just need to know as far as clinically there is going to be an approved PA out there but none of the claims will pay. Right? I guess I just want to make sure that… I think that the dosing limits kind of bleed into the clinical PA also. I know that it is a different piece of paper and it has already been discussed differently. I don't know if I'm making my…. I don't know if I am being confusing? If I need to explain it a different way…	

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	Dr. Klingler: Could you rehash for us what is a clinical PA versus a regular PA? Dr. Todd: Sure. Actually I mean, the computer system it's all… a PA is a PA, it is going to hard stop at the, at the pharmacy. The pharmacy submits the claim and you know if a regardless if… currently the clinical criteria that is in place that we have it broke down it is for antipsychotics for children ages 13 or younger, right? We have it into different classes and all of those drugs that we have been talking about are on there. This is the criteria that talks about criteria for prior authorization for antipsychotics prescribed to children ages 6 and younger. This is the one where they must be prescribed or in consultation/collaboration with a psychiatrist/neurologist or developmental behavioral pediatrician. Has to have the various diagnose… various diagnoses that we talked about or this board has talked about and this is the one also with all the weights and measures like to plasma glucose, and the weight circumference and all of that right and the one that has the onetime 60-day override. So if we… if the member meets all of that criteria I'm just concerned that if there is somebody that's under 6 and we turn around and we say well actually they can't have it here do we need to amend that clinical criteria to say that we are not approving it there either? Dr. Ellermeier: I think that's… Dr. Todd: Maybe I'm not… Dr. Ellermeier: I know what you're… I know what you're saying but I think… there's an exception for such drugs…Yeah. I think we are talking about that criteria next right on the agenda? But I think probably what we need to do is add a list to each of the age groups of things that are not approved like… Everything…You can almost… Dr. Millhuff: Lisa if you have a… an approval for an atypical antipsychotic in younger than 13 right now yet the dosing pattern does not fit dose optimization it will stop the prescription won't it? Dr. Todd: That is correct. Dr. Millhuff: So isn't that the same sort of scenario that with this if the dose exceeds the amount	

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	that we have approved on this other format that it would stop like the dose optimization would stop the dose? Dr. Todd: It would but there would be no option for the child to get it or I guess my thing is the difference in my mind and I am probably getting to technical is that dose optimization is really geared more around if it's the drug is designed to be given once a day then that's why if the drug… the claims comes over for twice a day that's when the claim itself will deny. But if the prescriber changes it to a once a day dose it will go through with a PA. If we say in this criteria that children under, you know, 6 or whatever age range we have blessed there's no approved doses then I think that could be confusing. Providers will say but I got a PA for this but now you can't pay it at all. Dr. Zhou: I have a recommendation is it possible to consider this not approved for 4 to 6 as part of the regular PA criteria and not the dosing limit criteria? Just so that when you are reviewing for the drug you can say oh this drug is not approved for 4 to 6 so I'm not even going to approve it to begin with for that 4 to 6 range. Dr. Todd: Right and then under that idea then the provider would have appeal rights because if we would deny that the claim denies you know or a provider sends it in and still asks for a PA and we say well you know our PA criteria says children, you know, under 6 they can't have this; then they could file an appeal. The medical directors or such could review that information and then you know decide whether to go ahead and override it and pay for it. Dr. Millhuff: If our clinical PA for the use of this medicine in age group also includes a box that says that the, for that patient in that age range they are selecting a drug that's approved from our, that the dosing is within the dosing range. We put that in our clinical PA? Is that what you are saying? Dr. Todd: Yes, that would be… Yes I think that would be easier for providers. It would… it would just and easier for our helpdesk folks and just operationally everything; just to be clear. Dr. Millhuff: I agree. Dr. Todd: Because you don't want I mean that's that would be like the worst thing providers are like I got a letter that this drug this drug is approved why isn't it going through? You know.	

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	Dr. Adma: So what would that be in this column? If you go with that knowledge. Dr. Todd: I think we would still leave it as not approved but then we would just need to make sure that like Nicole had suggested maybe taking this table and making it part of the clinical PA as an attachment for reference to know and then we'd have to amend the clinical PA criteria to change it so it matches up with what you have decided on the dosing. Dr. Adma: Okay. Dr. Todd: Does that kind of make sense? Dr. Millhuff: Yes. Dr. Todd: Okay. Thanks for hearing me out; I just didn't want to…. I want everything to go smoothly. Dr. Mosier: Based on that discussion does somebody want to make a recommendation/motion to combine the two in essence? Dr. Ellermeier: I think that we should still keep them as separate but I think the things that are not approved should be added as not approved to the clinical criteria. Dr. Mosier: Alright. So is that a motion? Dr. Ellermeier: Yes, a motion that we add the not approved items to the clinical criteria for age. Dr. Millhuff: Are we getting ready to look at the clinical criteria next? Dr. Mosier: Yes, that is why they are kind of paired together today. Dr. Millhuff: I have a very simple one; I recommend in the title it read… Dr. Mosier: Wait. Wait. We haven't voted on this one.	

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	Dr. Moeller: I second that. Dr. Mosier: There was a second? Dr. Moeller: Yes. Dr. Mosier: Thank you. So all in favor? {Several 'Ayes' are heard} Dr. Mosier: Any opposed? {Silence} Dr. Mosier: Okay. Dr. Millhuff: On the title it says antipsychotic dosing limits in children less than 16 years of age; I just want us to add 'children and adolescents'. Dr. Moeller: I will second. Dr. Mosier: All in favor? {Several 'Ayes' are heard} Dr. Mosier: Any opposed? {Silence} Dr. Mosier: So it is children and adolescents. Any other changes to consider to the antipsychotic dosing limits for children and adolescents less than 16 years of age? Dr. Adma: There are some on the list with some of the atypicals are not approved versus requiring	

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	prior authorization; any thoughts on those list of antipsychotics? These are the newer antipsychotics. Dr. Moeller: I kind of was wondering; I first said at the last meeting like the real new ones like Rexulti, Brexpiprazole. So, I talked to my colleagues who work in child psych and no one's really seen them be used but I could see that possibly being requiring a PA but I would leave that up to… Dr. Adma: Of the new ones the only thing, the only medicine I might have used some time ago is Saphris. I have not used any of the others. Dr. Moeller: Saphris has a dosing. Dr. Adma: But not under, not for 4 to 6. Chip, when you use it on your kids, have you used any of those non-approved or do you see that being a challenge of because once you say not approved then you have to do the… Dr. Millhuff: I would just put it this way Vishal, I feel very comfortable with this list that I can live within the ranges of this list and I do not use those newer meds. I am looking for more evidence of that. Dr. Porter: I have a thought about it, it bleeds a little bit maybe into the prior auth. Some of the other things that we have discussed and that could be a can of worms but currently Kansas Medicaid pays for genetic testing. Another, to me this wouldn't really affect the 4 to 6-year-old group which we are talking about 31 or 28 patients but maybe the group above that and certainly the group above that this would be… let's say you have done the genetic testing that Medicaid pays for and it suggests that this persons profile fits best with one of these newer agents which does happen because they tend to be pretty clean agents. Wouldn't… I think because that could happen I would suggest considering on some of these newer ones and it's not just the newer ones by the way but Mellaril and Navane that we might consider moving it to prior authorized rather than not approved and considering that this would be a separate part of our discussion would we have the information would suggesting genetic response as part of the prior authorization review? Something that would be considered. Dr. Moeller: I had asked for Thioridazine to have not approved on all age ranges just because of all	

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	of the significant side effects and in the justification of using it nowadays. I think it is pretty limited to even find the drug now but, Dr. Porter: Right. Dr. Millhuff: You know Ty I think it's a good thought what you are saying but you know there is just so much we can do with these lists in terms of I think simplifying what we do and adding the gene site testing or what not I think that's my view I think that would be more complicated. Not just in terms of… I am just telling you how I see it I look at let's say this age range of even 10 to 16 I am looking at maybe a fifth or sixth grader. So much variability even with the results I see on the genetic testing in terms of efficacy and I certainly... I am just saying personally I don't look at that as a strong guide as to what… I wouldn't choose a med that's there is very limited evidence for its safety and effectiveness in kids wouldn't choose that over a med that has robust evidence. Let's say like Risperdal or Abilify based on just the genetic testing. Unless they had already been to a trial of these others and found there's a problem and then I guess if you ended up getting a PA you could say well I've tried these other meds. Dr. Porter: I think we're talking about small numbers of people. That is kind of the scenario assuming usually you don't order that until you have been through a couple things that didn't work and it's usually going to be the two you mentioned in the little ones of that category so then you are choosing a third one and I would then… Dr. Grinage: Which is a newer drug usually. Dr. Porter: Which might be one of the other ones; not approved and not as heavily used for that group but I think at that point I could see a psychiatrist saying, okay I am going to order the gene site testing look when it comes back and only these two that… and I'm not suggesting that we don't… my suggestion would be, would we consider moving that from a not approved to a prior auth. It's still require additional documentation of why we want to use it but I'm also fine… threw it out for discussion and I think it would be a very small number of people that it would matter too. Dr. Ellermeier: I think that we could leave it as it currently is as not approved and they would still have a route to get that medication through the appeal if that were the case.	

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	Dr. Porter: Okay. Alright. Dr. Adma: Chip has done a lot of work on this so thank you for doing that. Dr. Mosier: Any other comments, changes? Dr. Zhou: I do have a question operationally so when it says prior auth requires, what kind of criteria do we want to follow? Are you asking the MCO's to follow when it is a dosing that requires prior auth? Dr. Ellermeier: I think… I think it would be… Yeah… just the criteria for all. Dr. Zhou: So anything exceeding dose or… because this one only talks about dose and exceeding dosing but also anyone that requires PA, would call it this. I just want to make sure. Dr. Moeller: I was just kind of wondering that thought as you were talking because I guess like we said all antipsychotics in children and their prior auths. By having, if you scroll down to the column, if I am understanding this correctly so for like that aripiprazole, we aren't actually, we aren't establishing any dosing so, so the PA would just be the other criteria? Dr. Zhou: Or do we want a peer to peer also on top of the… {several people trying to talk over each other} Dr. Ellermeier: I was thinking the peer to peer. Dr. Mosier: This is just specifically about dosing. Dr. Moeller: I was thinking like I guess a peer to peer; why are you using this. Dr. Zhou: Yeah. We just need to be clear to the MCOs and for what you would like for us to do. Dr. Mosier: And we'll do that. I think we will get that taken care of but I don't think that's the role of the committee. Any other changes to this?	

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	Dr. Ellermeier: I think it is our role to make sure that if it says requires PA in this table we are not talking about this clinical PA; we are talking about drug specific like why is the patient getting this particular medication if we don't think it should always necessarily be always prescribed in that age range. So I do think it goes with the criteria that is on page one of this document. Dr. Moeller: Yeah I agree. I thought I think that's our role. We are here because I think there are all a little confused on this PA because this is a second step is what I'm guessing. Dr. Friedebach: What you've kind of voted into place. Ms. Grant: May I get the microphone please? Dr. Friedebach: So, what you kind of voted into place is this whole policy then being laid into your other prior authorization criteria in some ways and if you scroll up to the top you have, I'm sorry, you have that requirement for requiring for peer to peer consult with a health plan psychiatrist, medical director or pharmacy director for approval. You know one of the things that I think we may need to be looked at and should consider is what are those circumstances when it seems this dose might be appropriate. So is this someone who just recently got out of the hospital? Is this someone who has failed multiple medications? I mean so whether you use this policy as direct back to that prior authorization criteria or you put what you feel justifies this exceeding that would be an option for you to consider if you want to have that here. Dr. Klingler: I don't know. Dr. Porter: Just for internal, for consistency though we've been talking about the PA process separate from the appeal process. The appeal could be standard or it can be expedited peer to peer. The prior authorization what it says in the sentence right now is we were talking about a form rather than a peer to peer so we probably need, if I am understanding what we were talking about, we probably at least need to change that sentence cause it makes it too synonymous; prior authorization and peer to peer consult. Dr. Friedebach: Yes, you make it accomplish to your point by taking that bullet out so that is not requiring that and leads you back to your prior authorization criteria. That might be easiest.	

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	Dr. Mosier: What you are saying is if I am understanding correctly is that on this one you remove the statement under the criteria for prior authorization and then instead this is referenced in the other clinical criteria? Dr. Friedebach: Yes, if you read dosing exceeded listed in table one will require a prior authorization and you leave it there you kind of guide it back over to your prior authorization criteria. Dr. Ellermeier: But they've all already been approved based on that criteria to even get to this dose; to get to any dose. Dr. Friedebach: Well the only, again I think the only thing you have decided you want do you want to require a peer to peer conversation to exceed this dose? Dr. Adma: The answer is no. Dr. Friedebach: So then you, that's what you don't want you want it to have the potential for a written then you may drive it back over to your prior authorization criteria. You know you're as it is now you are kind of creating another thing that has to be done to exceed the dose when you could drive it back towards your prior authorization criteria. If you wanted to do that and I think to your point in saying this does need to be addressed in this policy is right because this policy is directing a very specific process maybe intentional or not but if you want to drive it back to your prior authorization criteria taking that second bullet out requiring the peer to peer would then bring you over to your prior authorization and maybe you can put a peer to peer component there if you wanted it but just for your consideration. Dr. Ellermeier: I'm sorry but that still doesn't make sense to me that all kids would have to have a PA to get clinically to get an antipsychotic at any dose and then we're saying you can get up to this dose but then once you exceed this dose go back and get approved based on the criteria they were already approved on? That doesn't make sense. Dr. Friedebach: Well you either have to, you either have to have one of those two options; you either have to say you can never exceed this dose, period, or you have to have something that	

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	allows them to exceed that dose and so in criteria and the criteria that you have is that it is going to require a peer to peer conversation with a plan psychiatrist. Maybe that's what you want but if it's not then you can… because ultimately your reviewers are going to be looking at these two things in concert. Is kind of what we are trying to accomplish to some extent. Dr. Porter: Maybe we can walk through a real-life scenario with the three MCOs and see if everybody handles it the same. So I get a kiddo in my office and let's say I made a good determination that the patient has responded partially to a dose of medication and maybe I even know that they are a rapid metabolizer 2D6 and that they're going to require a dose higher than the one recommended here; let's say this happens and I fill out a form, one that looks really nice by the way; we haven't gotten to it yet and who's if I do this explanation for what my thinking is that goes to somebody at one of the MCOs and they look at it. Do they have the authority? Will my clinical description make a difference to that person or will that actually need to go through the psychiatrist for them to make sure I'm making sense? Does that… is that… that would be the thing that we are hoping that the form will avoid playing phone tag but if they can't… if they have to deny it anyway because it doesn't meet the criteria why do it? Dr. Zhou: So if the committee I think is very specific guidelines on when you would like for us to approve then we can go ahead and up that kind of criteria so let's so ok the patient already tried two or three medications, the patient has just been in the hospital that type of criteria that would help speed up the process cause the reviewer can quickly go through and say oh that is one of these criteria without having to pass it on to a psychiatrist. I think that was one of the issues we were you know kind of saying you know it takes us a lot of time to pull a psychiatrist, to clear their schedule to meet and discuss the case. So if the committee is able to come up with those criteria then we can make the process a lot faster or it doesn't it doesn't have to cover every single case possible but when if covers you know, let's say 70 to 80% of the most common cases I really think that would help the process along. Dr. Adma: Thank you for pointing that out because, you know, we have been contradicting ourselves and my thinking once you broke that down to me in terms of prior authorization and what would be required to be a peer to peer consultation. In terms of the criteria I think if somebody is recently discharged from the hospital that should be one of the things that should be under your reviewer side or something like because often I see patients getting discharged from the hospital and then now their stuck in the pharmacy and not able to fill that. So at least for a 30-day	

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	supply until the outpatient psychiatrist can figure it out. So that is something that I certainly want all of the three MCOs to approve that. Dr. Klingler: I have one other question on this in looking at what you have pointed out at first saying we will require prior authorization and we are looking at max doses does it make any sense on the table under the 10 to 16 year olds to say requires prior authorization when we don't state a maximum dose is what we really mean for that not approved? Dr. Moeller: That is what I was… Dr. Klingler: I think we need to change all of those to be consistent to not approve because now we are saying we need a prior authorization for a max dose and our max dose is listed as prior authorization. So I don't know if that gives anyone any guidance when you justify that with the table. Dr. Millhuff: And looking at this I'm looking at the line that says doses exceeding those listed in table one require prior authorization; what if it says doses exceeding those in table one and medicines not approved will require a prior authorization? Dr. Porter: The only catch there would be again in the distinction between prior authorizations, requires PA and needs an appeal. Dr. Mosier: The not approved goes through the appeal process rather than the prior authorization process. Dr. Moeller: I think to make it more clear I think we need to take out requires PA for everything. Is that how others would that make it easier for the MCOs? I mean really I guess the 'requires PA's for only on the long acting so… Dr. Adma: Not approved for the long acting. Dr. Moeller: No for 10 to 16 year olds we still have a required PA. Dr. Ellermeier: Yeah.	

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	Dr. Moeller: Although, anything above these doses require a PA and that for… and right now we are going for peer to peer which I support at this time; the peer to peer. I don't… I would think so if someone goes above the max it a PA not an appeal is that how it's worded? Dr. Ellermeier: I agree with Karen I think it should be a peer to peer. The reason is we're not going to be able to account for every single clinical scenario that is going to happen with these patients to say why they should be getting doses above these limits but we think that these limits are reasonable and should cover the majority of what patients are getting so it is going to be one offs that are going to be above this. So to try and come up with structured criteria to account for every single one of those one offs I still think it's going to end up being a peer to peer or some sort of rationale that has to be provided that is not just a check box. Dr. Moeller: What do you think about the long-actings? And then in the 10 to 16s? Should we, because we don't have a criteria. Or do we need to define with the PA? Dr. Ellermeier: I think we could just say it like, we're talking about this one policy; the criteria is page one of this policy. Dr. Moeller: Okay. So then 'requires PA' would stand for a peer-to-peer. Dr. Ellermeier: Yeah, or we could just say 'peer-to-peer' in the table, if that's more clear? Dr. Porter: And that's also saying it's not approved? Dr. Ellermeier: 'Not Approved' goes to the appeal; directly to an appeal. Dr. Porter: Okay. That's different than a peer-to peer. Dr. Grinage: Right, and that's where my confusion is. As far as letting providers know that 'not approved', I mean, that's a mental block right there. I like the idea of 'would require appeal' so that people know that there's differences with 'require appeal' versus 'peer-to peer' versus 'PA'. I think that just needs to be clarified because it is pretty confusing.	

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	Dr. Klingler: We have 'requires a PA' under 'Max daily dose'. So what are they basing the PA on if we haven't' given them a max daily dose in the 10 to 16s? Ms. Todd: Then it would just be an age limit? Dr. Ellermeier: Then it's the peer-to-peer, that's what the PA is. Dr. Klingler: To set the max daily dose? Dr. Ellermeier: We're saying 'No dose is approved. You have to do a peer-to-peer'. I think that's what we're saying. I think we could use the same language across the board for when we don't want to have a specific dose listed. Dr. Adma: If you look at the form; and again I'm jumping ahead; it does say 'peer-to-peer verbal' and 'peer-to-peer written'. And the thinking behind it, I think, Ty's been talking about it for some time, is if there is a way that we can avoid psychiatrists or nurse practitioners to avoid a phone call and write down the reasons why they are prescribing the way that they are and it can be approved looking at that, you know, documentation. That would be certainly the first line of review versus phone calls all the time. Dr. Mosier: A lot of different things discussed here. I think I'll go to the most recent point. I think about having the opportunity not to have a, having a peer-to-peer written or verbal was one of the things we were responding to your request that have been made we want to preserve that to help with time management for everyone. So I think that's one of the things we want to make sure that it's one of the things that is included here clearly. The other thing, as we were discussing with 'not approved' or 'requires a PA', I kind of wanted to go back to what you were saying about Texas; so they, what were the things they had in their table? How did they define? They had, did they have 'requires PA' or 'not approved' or did they have different [language]? They had one, I remember, that was more about 'not defined' or whatever. Dr. Adma: From what I could understand it was 'not approved' meaning 'not FDA approved'. Dr. Millhuff: Correct.	

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	Dr. Adma: 'Not approved' does not mean not approved by the committee or not approved by the insurance. Dr. Millhuff: What they did is they had the initial dosage was one column; where you should start with these meds. And then they broke it down even into age ranges, which is a nice reference. And then they went on to the literature based maximum dose. And then they had a column for the FDA approved maximum dose. So you can compare and contrast. And then the dosing schedule. And then they included their patient monitoring parameters. Which was the same for all of them. Dr. Moeller: I think that's more of guidance, isn't it more guidance and not actually procedural, but does it say it 'requires prior auth' or 'not approving'? Dr. Porter: That's right. Dr. Millhuff: What it says in the criteria indicated, I'm sorry, criteria indicating need for further review of a child's clinical status which this is not a PA process, it's my understanding, it signals just a review. Is, they say 'The psychotropic medication dose exceeds usual recommended doses (literature based maximum dosages in these tables).' So their limit is on the literature based max. And so they're definitely referencing that in their list of overall clinical criteria. So it takes the reader of this directly over to this very comprehensive table. And I, when I put numbers in here, I errored on the side of the highest number that was listed in the literature based numbers on this table here. Does that answer [your question]? Dr. Mosier: Right, I was wondering what specifically how that related to our document here, and as Karen said, it's really more of a guideline as opposed to what we are operationalizing here with prior authorization. Dr. Millhuff: So if you look at the column that says 'literature based maximum dosages'; if you just want to say that that's the key column in their reference, when it comes to a medicine that they do not approve on the anti-psychotics, what the language is, is simply 'insufficient evidence'. That's all it says. Dr. Adma: So, looking at the table that we have in front of us, if the three MCOs want to operationalize this, what are the hurdles? At least we can address those hurdles and then start	

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	moving this forward. Things that you see as hurdles in operationalizing this and then so we can hear, one at a time, and we can come up with, well, how do we address that. Dr. Zhou: For us, I would say the part that says 'require PA'. If you could go up, it depends on what you want to do with that bullet up there. If we could just say, 'see dose listed in table one' as well as 'any drugs that states require I guess PA in the chart', will require…will need to meet the following criteria. It talks about requiring PA multiple times but we don't know which PA you are referring to. Because we got this dose PA and we got the other clinical PA. As long as we clearly specify what criteria we actively follow I think it would be straight forward. Dr. Adma: So let's type up whatever you're saying Angie. So, doses exceeding dose listed in table one and? Dr. Zhou: And the drugs listed as requiring PA. Dr. Adma: And the drugs listed as requiring PA. Dr. Zhou: Will need to meet the following. Dr. Adma: And then list whatever that 'following' is? Is that what you're saying? Dr. Zhou: Yes, the following, then it will tell you what the following will be. Dr. Adma: Any other suggestions? Dr. Grinage: Could I just clarify? They already have to go through a PA process being a particular age, in general, correct? Unknown: Yes. Dr. Grinage: That is one PA. Unknown: Yes	

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	Dr. Grinage: Then you're talking about something else, and so I think that has to be defined. And those are two different things. I don't know if a secondary review for going over doses or using one that is not approved would be a peer review or an appeal process. I think those need to be defined outside of just saying a PA, because they all are already in the system because they've been approved by PA, right? So calling it a PA again inside of that is where a lot of confusion comes from. I think the secondary process would be a different type of PA or appeal process or peer review depending on what the committee would think is the appropriate level of review. Is that kind of, am I understanding it correctly? Ms. Todd: Yeah, so right along your lines of thinking, right, and I'm, I was just thinking, and I think Dr. Mosier talked about that, that we will be talking about the clinical criteria, but it almost makes sense to me, now that we are talking about dosing limits for children is, why not just incorporate that into the dosing limits and the age limits, we can do both, into the clinical criteria so then the provider only has to contact the MCO one time. Dr. Grinage: That was going to be my next suggestion. Ms. Todd: Right, so we could actually in the clinical criteria where it talks about ages 6 and under, if there's a specific…if you don't want to cover it for 6 and under…we can just say that and say, you know, 'denied, deny this not covered, please send appeal rights' or if you do want to cover certain up doses…we can make that part of the questions. Is the, you know I don't even know what the dosing is, let's pretend it's 20mg with what you, the board has approved for a certain drug, but you could make that part of the other clinical criteria, you know…'did the member meet the diagnosis?'; 'has it been prescribed by this certain provider?'; 'is the dose that's being prescribed over 20mg?'; 'yes or no?'. If it is 'no' then the whole thing denies and all of the information can be reviewed at once, as opposed to 'well, yeah, we give you part of the PA but now we're not going to give it to you because of the dose'. Does that kind of make sense? Dr. Millhuff: Yeah, so if we combined the two would you then, when you initiated a medicine, you have to do the whole form, initiating this med in a child or adolescent would initiate the whole form altogether. And, hopefully, they'd be low at the beginning but if you then, down the road, exceeded the dose, would you come back and do the whole thing, the whole form again? Ms. Todd: That's a good point.	

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	Dr. Millhuff: Two points you get, it kind of makes sense. Ms. Todd: We could, honestly, build it either way. Dr. Millhuff: The other thing is the, what we've been living with, was new PAs every time we change the dose. We don't want to have that, particularly if we are in the dosing range that's been approved. Ms. Todd: I think Annette can probably speak to that. But we've had conversations before this meeting about rectifying that issue, in general, for all of us. To make sure that you know, you can switch strengths without having to get new PAs. I think we're all moving towards that. Dr. Adma: I think one solution that I'm thinking is that, if there is a way to combine the dosage limits and the age limits into one document? Ms. Todd: And the clinical. Dr. Adma: And clinical. Ms. Todd: Both, all three. Yes. Dr. Adma: Then I think it makes really good sense. Long term also. Ms. Todd: Because from an operational standpoint, what we do is we take these statements that are on this clinical criteria and we create questions, you know, like yes or no questions, to make sure that the members met all of the criteria. What's a challenge is when they're in different documents, then that's different sets of questions, different sets of forms, or different outreaches. So if we could put it all together in one, then it's all one set of questions. We could even do, like if you want to say for a member of a certain age, that if they meet the clinical criteria, they have the right diagnosis, it's prescribed by the correct provider, then the PAs approved if the dose is within whatever range, then that PA would just be approved. But if it actually hits a question that it, all the other questions are yes, and it would approve except for the dose, then you could say that specific question requires a peer-to-peer, otherwise, you know, you could get that specific if you wanted.	

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	Dr. Mosier: What I would propose with that in mind, is that we move to discussing the additional criteria and then talk about it the context of combining it, and kind of walk through that and see if that works well. Dr. Ellermeier: I want to bring up a couple of points. First, our age ranges don't align between the two, is one problem. The other problem is, we still need to address what we want to have happen on doses above what we say is approvable. I still see them, I see these as issues we still have not resolved and combining doesn't fix that. What do we do above these doses? Yes, we can move forward with combining, but then what's the process? Dr. Porter: I would think that those cases would be unusual enough that, as a provider, I wouldn't mind being asked to explain myself to somebody, you know, to a peer. But I think I should be able to in writing, describe, or even my notes should explain why I'm doing this unusual thing because it's unusual. So, I assume that we would expect it would go to a peer review or another psychiatrist. Dr. Ellermeier: So kind of what we have written right now. Dr. Porter: Well, except for, yes, we're kind of talking about them as if they are two separate things, but we're really talking about an appeal or being a peer review now. Except for, there's a prior authorization over if they've got their weight and their labs. But if we're going above the dose or we want to prescribe something that's not approved, I wouldn't be ashamed to defend my case if I was going to do that. Dr. Ellermeier: So, sorry… so you're thinking rather than saying for these dose limits the PA criteria is a peer-to-peer on a form, it would be the appeals process that may include a peer-to-peer? Dr. Porter: No, I'm thinking I prefer the form. Dr. Ellermeier: The form? Dr. Porter: The former. Yes, rather you communicate the information without phone tag.	

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	Dr. Grinage: There's a primary PA up to a particular dose, then after that you have to explain yourself. I think, Ty, what you're saying is that that would involve more written information but may require, and I don't know, I mean, this gets into the weeds, into very specifics as to whether 'it has to be appealed', 'is it automatically just approved', 'does it need to be peer-to-peer-to-peer', or 'can it be authorized just through written on a form', and that would need to be defined. Dr. Shoyinka: I certainly agree with simplifying the process. We're pretty much in agreement that starting an antipsychotic in a child below certain age, that physician should, or practitioner, should explain that below the age of 4, I think we made that point earlier, in addition to what you are saying. Above certain dose limits tie to older age groups and then that prescribing should be explained. Dr. Grinage: My understating is that all kids have to have a PA, right? That is my understanding; they all have too. Then I would say up to a certain limit they need to define what else what other steps to go through. Dr. Mosier: Can we hear from Amerigroup too operationalizing combining them no issues from your perspective as well? We will be talking through it here, stepping through it. Dr. Zhou: I am going to throw something out here; we could still potentially have two but adding the dosing onto the clinical one for initial review because later on we reject for over exceeding limit you can just use the single dosing limit one and not have to go back to the full clinical review one, as well. Dr. Mosier: An alternative is if you have it combined and it is just coming back for dosing you can have it defined within that policy as well. Dr. Zhou: Yeah. Dr. Mosier: Should we talk about the combining and walk through that. The big thing is the age difference thank you Nicole for pointing that out so we do have the less than four, the four to less than six but then its six to less than eighteen instead of… Or no, actually ten, sorry we have some more differences. We have six to ten and then…	

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	Dr. Ellermeier: Ten to sixteen and then sixteen to eighteen. Dr. Moeller: I guess we would just say sixteen to eighteen would be the adult. Dr. Porter: I think the catch is to get back to this again I don't know the answer but you have sixteen year olds who have the same base metabolism as a 20 year old, so pharmacologically it's the, changing to 16 and under makes sense developmentally etc. these are minors though and some of them are in state custody so I don't know if that changes our, if we can go just physiologically or if we have to go back to the eighteen thing when they are of age to make their own decisions or if somebody else is officially signing off on the medicine. I don't have an answer to that but that's a dilemma on the sixteen versus clearer physiologically sixteen, it has to do with the law. Dr. Millhuff: What if we just say take eighteen to sixteen on this clinical criteria. Dr. Porter: Include them? Dr. Millhuff: Just not worry about the older than sixteen. Just keep it simple. Dr. Porter: Again, so if people are comfortable that these are people that won't be able to officially make the calls for themselves and a risk benefit discussion. They can have it when they are eighteen I guess. Dr. Moeller: Are you saying to take out the clinical? Dr. Porter: I actually am just throwing out the dilemma that we have medically treatment doses… what doses do you use; What medicines do you use; Sixteen versus eighteen but legally they are very different. Dr. Millhuff: But I think that… Dr. Moeller: We already changed the dosing if they are worried about you know the seventeen. The sixteen, I guess it's greater than sixteen so when they are sixteen and one day they can go to adult dosing. Correct? Sixteen, seventeen and then eighteen they are already out of this policy. Eighteen	

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	and one day that is how I print that but I think we thought really we should keep the guidance on they should have the metabolic monitoring and all of that. I would just kind of just for the sixteen to eighteen year old range just say keep the clinical prior auth but to say usual adult dosing because adults are going to have the prior auth too when they exceed the dose. We do this for adults too. Dr. Ellermeier: Yeah, I think we have it on the dosing limits as the reference so I can it can be added for sixteen to eighteen. One suggestion and if we don't want to do that that's fine but I would suggest we maybe focus on the changes we propose for the clinical criteria first and then move into adding the two together because we are getting things really kind of murky and kind of maybe try and get one thing accomplished at a time.	
II. Old Business B. Prior Authorization Criteria 2. Antipsychotic Use for Children less than 18yo	**Clinical Public Comment: -** No requests were received. Dr. Mosier: So we'll start with the next criteria and then come back to the combining. Annette if you want to go through the proposed changes. Ms. Grant: Ok so the first thing was the title to change to PA criteria for antipsychotics in children and adolescents less than 18[yo]. [Unknown]: Can you use the mic please? Ms. Grant: Yes, I apologize. So the first thing was to change the title so the title is antipsychotics in children and adolescents less than eighteen years of age. The second thing we added was on the diagnosis was PTSD with associated severe agitation. Then we went down we changed the DSM-5 to diagnosis instead of evaluation. We went down to the last bullet point and that paragraph is on the non-psychopharmacological interventions we changed that to and maintain if indicated during psychopharmacological treatment. That was the first page changes. Added the one time sixty override for this criteria that had been left out but it has always been an option so we added that to that age bracket less than four years of age. In the criteria for this age bracket again added the PTSD with associated with severe agitations. Changed the evaluation to diagnosis. Added the non-psychopharmacological interventions to if indicated. Move down to six to less than eighteen years of age, again adding PTSD with associated severe agitation. Changed evaluation to diagnosis and in this age group we did not have the non-psychopharmacological interventions they just had to be attempted.	***First Motion:*** Dr. Klingler made the motion to remove 'Requires PA' and replace it with 'Not Approved' in the less than sixteen year old column. Dr. Millhuff seconded the motion. The motion carried unanimously. ***Second Motion:*** Dr. Adma made the motion to approve the criteria as amended. Dr. Porter seconded the motion.

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	Committee Discussion: Dr. Mosier: Discussion? Dr. Adma: So the first the criteria for less than four years along the criteria is AIMS testing is listed. I want to ask the panel members for less than four years do we really want to have AIMS in there? The other question to the panel members is again for less than four years is that a requirement of the glucose lipids screening or we at least attempt it. Sometimes you know we will see a foster care kids on some of these medications and if it is required then we cannot give so I want to hear from the MCOs is that a requirement or it needs to be attempting to get some of these labs? The third point is in the same area the collateral information from community resources (i.e.: school) again less than four they might go to kindergarten. They are not in kindergarten in daycare so we might want to think about what additional information you want from what source because when we give these criteria bullet points to the reviewers they might just go by that and then the last point in that age is non-psychopharmacological interventions if indicated and the challenges again in the foster care population is parents may not be involved so with the exception to parents are not involved. Those are some of my comments I will let others comment. Dr. Millhuff: I wanted to comment that the very good points Vishal. We're going to get to this other form but, I'm wondering if it's relevant to think about this other form because it kind of takes the complexity of this longer form and simplifies it in free formatting it a little bit and also I changed some of the wording that is reflected on the prior authorization form. I think it kind of makes it a little bit more understandable so I don't know do we need to review these separately or can we also look at that? Dr. Mosier: I think we can discuss that. What we were doing with the criteria for the prior authorization for both of these is these are things that would move forward in the next step in the process, right, and so there I think the conforming changes may need to be made with the form or it might simplify by that but there are two separate purposes the form is for the prior auth for you to fill out and this is to go to the Drug Utilization Review Board. The forms won't go to the Drug Utilization Review Board. Dr. Adma: Should based on the form you are talking about can you suggest maybe updates, changes to this so that can really go from there.	The motion carried unanimously.

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	Dr. Millhuff: Yes. I think quite frankly in my opinion, the PA format is so much easier to read than the way we've got it broken out here because there are commonalities in each age group and we can list those right away and then when you get to the lower age group you just add the extra things so it does combine them. But one of the things I put on the, that I added that would go to the larger form would be for instance attestation about these various items. Attestation of attempt to track the following measures within the previous twelve months so those would be not documentation of attempted gathering of fasting glucose. I'm hoping that what the prescribers ask to do is just attest to the fact they have attempted to get these various measures. Rather than; we had a case recently where the medicine was held for a week while we were trying to provide the date of the physical exam when the a certain evaluations were done and so I'm worried that for not really specific we are just asking the provider to attest to this that we are going to be asked to put more into the review than what we are really asking for. That would be one example and that would be for each one of them on the lab piece. Dr. Moeller: The word attempt is in all in the original document, it's not a requirement. That was one of your questions. And that would include like the AIMS. Dr. Porter: I think we left some other questions open for discussion questions like the AIMS in the three year old I don't know about we need to get that out probably but the fifth bullet screening, patient assessments want to include screening; what operationally how what would you be looking for at the MCO end to prove that? I think that's where it gets the devil in the details how to meet that bullet for example. Dr. Zhou: I would say attestation would be what we would want. Dr. Millhuff: So on the other form this is how I wrote it for that. Are you looking at the less than four? Dr. Porter: Yeah. Dr. Millhuff: So this is how I wrote that up. Attestation that the patient assessment has included screening for parental psychopathology, evaluation of family functioning, and gathering collateral information from community resources. I will say working with many preschoolers that is the	

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	standard of care and we are trying to get away from you know using these meds ahead of looking at the social environmental factors and that's sort of pulling for this. Dr. Todd: Would you mind repeating that sentence again? Dr. Millhuff: You can read it off the other PA form I don't know if you got that in here but so attestation that the patient assessment has included screening for parental psychopathology, evaluation of family functioning, and gathering collateral information from community resources. It could be a daycare. It could be a school. Dr. Todd: And if the provider says, no, I haven't done any of those, then the PA would be denied. Dr. Millhuff: Right and it refers to the patient assessments so if an assessment; let's say you are a provider and you are looking at the assessment that was done by the social worker you can say yes that was in our evaluation. You would check the box yes. And the same thing follows for the next one in terms of I rewrote and I'm sorry you guys rather than non-psychopharmacological interventions I wrote that attestation that non-psychopharmacological interventions, such as training parents in evidence based behavioral management, have been initiated before psychopharmacological treatment. Dr. Ellermeier: I appreciate the point of adding attestation to the form. I get where you are going with that and I agree with it, but I think simply just asking has the patient assessment including screening for parental blah, blah, blah, having yes or no that is simply an attestation. I don't think we need that word defined on the form I think it needs to be defined in the criteria. Cause the form… Dr. Millhuff: That's fine. Dr. Ellermeier: This is what the provider is going to fill out but this is what the reviewer is going to go off of. Dr. Millhuff: But then will then the reviewer say can you give us the date of that assessment? Dr. Todd: No.	

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	Dr. Ellermeier: Not if we put attestation in the criteria. Like we're just saying… Dr. Millhuff: Oh, okay. Ms. Grant: I guess I just would like to make a comment. I did update this we did several things that we went over in the last meeting we're going over and changing this meeting and I did send the documents out a couple of weeks several times throughout the last meeting for updates and then I even incorporated this very most recent update into the forms here but it sounds like we're revamping both things all over again and I think this is the third time we've discussed this so I'm not sure today if that's possible to put these two forms together and get it voted on today and I'm not sure I know that you wanted these improved criteria so you can get them implemented sooner. If we don't get it approved today then that leads to another meeting which is three months down the hall and then by the time the MCO's implement it 60 days later you are looking at four to five months after if you want any of these updates to be done. Dr. Porter: Yeah we're still getting the waist circumference thing we agreed not to do. Ms. Grant: That is because we have not approved the updated criteria. Dr. Porter: I know. I am just making a point illustrating your point. Dr. Millhuff: I just want to speak up as a member of the committee and say that these kind of practice; try taking a practice it takes a lot of time to learn how to do this stuff. We are trying to put this into this criteria looking at other systems. These are triggering reviews and not PA's. I just as a member of this committee I think we're trying to do is so complicated and hard I think in some respects I think it is taking time because it is too complex to use through this method of a PA. There are so many variables here that we're trying to measure and I'm a little bit frustrated is why I keep kind of pushing here with this and Annette I agree with you what we've got right now is not working very well. I mean we need to refine it more so I can kind of back off on what I keep pushing here with all these refinements if we just if the committee just wants to press on with what we've got I understand that. Ms. Grant: And I think the criteria as we've brought today left us is we can vote on and if we go to	

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	the form you'll see that the form that you guys fill out that's the most updated very efficient for you and the sooner we get that approved then they can start changing that in their system and then you can see the benefit from your side. Dr. Millhuff: Right, okay. Dr. Porter: Vishal, brought up a point later I'm trying to see where this is earlier I should say. The person coming out of the hospital, their on a dose. It may be anywhere you know firing off a red light in any of the ways we've talked about but they're coming out of the hospital on it. I think generally the way to adjust their medicine is not at the pharmacy so is there a way to put that criteria into this somewhere that they get either thirty to sixty days if they are coming out of a hospital on it even if it's outside of any of this? Ms. Grant: One of two things, I did draft a policy that states five days and hopefully then you can get that. There is a three day already but it's not well known in the pharmacies so I've been trying to educate them on how to process that. Dr. Porter: I just think the timeframes like right now at Bert Nash in Lawrence it might take you eight weeks to get an appointment with a physician. Dr. Moeller: It does say and maybe I'm confused but we did put in a sixty day override. It says right there in the criteria. Is it something different that we are talking about? Dr. Adma: A brand new medicine though if it is something that they have adjusted and exceeded the dose on. Dr. Porter: They have come out of a hospital and they are on something that shows not approved. Dr. Moeller: I think I'm really confused on and maybe this is it; I thought we were talking about the clinical. I thought we were out of dosing right now. Dr. Porter: Well let's say it's, maybe I did go back I think either way for whatever reason if you go to the pharmacy and you are on medicine and you just got discharged from a hospital a three day or a hard stop right there I think is a problem to be avoided.	

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	Dr. Millhuff: Well Ty if it's a new medicine there is the sixty day grace periods; you would have that. You could start everything and it wouldn't be stopped at the pharmacy is my understanding. If it's within the parameters of the dosing amounts. Dr. Porter: What if it's not? Dr. Millhuff: If it's not? Dr. Porter: On any of the criteria we've discussed. Dr. Millhuff: Then that's where this new protocol that Annette was just referencing would kick into gear to give you five days but that's then the other problem of what you're saying what if you can't get into see someone. Dr. Porter: Right. Dr. Millhuff: So in the hospital when you start this. Dr. Porter: Medicaid doesn't know anything about that. Dr. Millhuff: So that's what, So they don't know they don't have to go through this process. Dr. Porter: No. Dr. Adma: Because the hospital pays for the medicine. Dr. Porter: So they find out when they go to the pharmacy, as Vishal said, that they are an outlier. The patient's just trying to feel better whatever and they can't pick up the med and again they may be a while before they see their doctor and maybe this; I think the response I'm getting is this is outside of this discussion, but we're looking at all these important bullet points and I can't think of, to me that's a very important one. Is the one that we really don't, that there's going to be a change at the pharmacy window, which isn't, and I know pharmacists are clinicians in a way, but I don't think they're wanting to adjust antipsychotics at the window.	

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	Dr. Millhuff: This is I think where I vote for more of the review then a hard stop. A review solves some of these issues Ty, it means you can still get it filled but then it comes to the attention to look it over. I know that's not what we are trying to do here but. Dr. Porter: It's expensive also if a patient gets re-hospitalized because they went off of their medicine. It is compassionate but it's also practical for taxpayers and everybody for that not to happen. Dr. Mosier: Well we've gone far afield again. Dr. Porter: Far afield, okay, I'll take that. Dr. Mosier: What's that? Dr. Adma: Every time we meet we go through this. Dr. Mosier: I know, we do. I know you're going for the review; I would actually like to go through and going back to what Nicole said to kind of consider what is on the table and at least get through that. Talk about the combination kind of follow that roadmap we just talked about and the sooner we land at that point. Ms. Grant: Criteria first? Dr. Mosier: We went through these criteria's so and then you had, you had some concerns that you brought up. What other one's have we not yet addressed? Dr. Adma: So let me just go through one at a time. So let me just go through one at a time on the criteria, prior authorization criteria. Number one about AIMS evaluation. Do we take that out? Dr. Millhuff: Why would we take it out? Dr. Moeller: It says attempt so…	

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	Dr. Adma: Ok. So when you look at this form that the reviewers will look on the physician to fill out it says attestation of attempt to track so does it which means if they don't check one of these, I mean all it says is check or no check which means? Ms. Grant: Are you in the form? Dr. Adma: Yeah. Ms. Grant: Okay, I apologize I'm on the criteria. Dr. Moeller: Should we should we I think we are trying to save the form until after we decide what to do, correct? Because we may make changes on this that will make changes to the form so I think we should just kind of make the form admissible at this time. Dr. Ellermeier: I would agree. Dr. Adma: So I've been saying that the documentation of attempted gathering of all of these within the last twelve months? Is that including less than four years? Dr. Porter: And the point being can you do an AIMS on a three year old? You know can they do a finger you know finger to finger? Can they follow the directions required? I don't think… Dr. Adma: I've never done AIMS in a four year old. Dr. Porter: It's not a big point but I think we should take that out. Dr. Mosier: For the less than four? Dr. Millhuff: I will say I had a four to five year old that has had abnormal movements and I've done AIMS on them. It's not a very common thing. I think the main question is would we catch abnormal movements if we checked for it regularly. I don't see it as a big deal because I'm not, there's not very many kids going on an atypical. Dr. Porter: We are talking about three year olds, there is a big difference a five year old ability to	

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	follow instructions and a three year old. Dr. Millhuff: Right. Dr. Porter: That's my point. Dr. Millhuff: Right. How else are you going to check for abnormal movements though if you're going to do that? Dr. Porter: I agree with you. Dr. Millhuff: I'm going to get down in my little chair right in front of them and walk them through it, which is what I do. Dr. Porter: But a three year old. Dr. Moeller: But it's a documentation. Dr. Millhuff: It could be a three year old eleven month old who looks like a five year old. I'm telling you this is what I do and it's you have to adapt it to the age and kind of do it with them and show them what your doing so it's a good question but I mean I've done it. Dr. Porter: Okay. Dr. Shoyinka: And I have to add to thatt, I mean you know this is a lot of these kids end up on these medications for years, right, and I think it's we're talking about safety measures with a very vulnerable population. It's not asking too much I don't think. And to answer the question just not very long ago just a couple of weeks ago I ran into one of our members who developed TD at age five, tardive dyskinesia at age five. Dr. Porter: My point, which I retracted, thanks to Chip's feedback would be that the actual AIMS exam that I'm thinking of requires a lot of following of instructions that at that age can't. It's not that I'm minimizing the importance of abnormal movements in children. It's very, the reason, the main reason we need to be careful with these medicines is that.	

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	Dr. Klingler: And I think that's where pediatrics is different than grown-up medicine. We adapt a lot of things; concussion protocols, AIMS, different things to the developmental age of a child not necessarily their chronologic age. Would that be a fair statement? Dr. Millhuff: Correct. Dr. Adma: Ok so I believe then, what I'm hearing is that we will keep those list of things, items. The other thing is the DSM-5 is listed now DSM-5 diagnosis; Do we say DSM because with time it might be DSM-5TR or DSM-6? Do we change that to most recent or most updated DSM-5 diagnosis; DSM diagnosis? So that way it's not just now but in the near future if that changes too because that might change with time. So my suggestion to the committee is most updated DSM diagnosis instead of giving a number. Dr. Klingler: And change that on each criteria? Dr. Adma: Yes, is the group okay with that? Dr. Millhuff: My only comment is that some people, you would think most people would know what the most updated DSM is and some people don't so I agree with what you're saying but I don't know that. Dr. Mosier: Or you could do, that really wouldn't do it. DSM or 5 or most updated because at least you get a diagnosis 5 level. Dr. Adma: Okay. Let's go with that. So DSM-5 or most updated DSM diagnosis. Would you be okay with that change? Okay. And then the next one in the criteria is non-psychopharmacological interventions, sorry before we go there how about the community resources i.e.: school. Before that that's the fourth point-fifth point. Do we say they go to, I guess, daycare right, so do we say daycare or do we say, some kids might grow up in home so. {Several people speaking at once.} Dr. Adma: Ok, and then non-psychopharmacological interventions in terms of the evidence based behavior management and I guess that might apply to kids in foster care, too. Cause the behavior	

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	management might apply to foster care so that's fine. Do we do all of these changes across them? In all of the three criteria? [Unknown] sounds of approval Dr. Mosier: I just see what you're saying Dr. Millhuff, about if we had a similar format then you wouldn't have to make conforming changes they would just be in there once. Dr. Millhuff: Right. Dr. Adma: Do you want to stand a motion then? Dr. Mosier: Is there anything else that you would like? Dr. Adma: Lisa? Ms. Grant: I don't know. Do we let Lisa do that? Dr. Todd: I was just going to say that this is the, these are the sections that you could add the dosing limits or the age limits in here if you want to put it all in one criteria. That's the only, before you make a motion. I just didn't know and you could split out if the ages don't match, you know, like the chart doesn't match you could say well zero to four; I'm just making up dosing. You could specify that in, within this criteria. Add to it. Dr. Ellermeier: Can I ask a question? If we were to combine them today does this have to come back to us before it goes to DUR? Dr. Mosier: We have two options, we can combine them and then do a top to bottom review here and if it's the group consensus they want to go ahead and vote on it today we can do that because it's really it's the same thing it's just combining them. It's not a new policy that we are looking at or we can bring it back. Dr. Todd: I'm not trying to muddy the waters I'm just, maybe kind of confused.	

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	Dr. Ellermeier: So I think whatever we do that we have heard there are some challenges with the criteria that's currently in place so I would not want to delay getting these changes in but I can also see if we want to combine them that it might be beneficial to do that today but I also think to get these changes that I think are going to help with what's happening today to maybe approve this and say as is if we are good with this, this moves forward and then let's talk about combining and do that final review for the next time. I don't know if that makes sense or not but I don't want to delay this again if you know if it can improve what's happening. Dr. Grinage: Why couldn't you just put in a statement to say, accordingly, you know, the antipsychotic use for this chart? There's not anything below the age of four but you could just say for our for antipsychotic use criteria needs to meet this particular attached chart. Dr. Millhuff: I agree. It could just be an extra bullet on each age range that says… Dr. Grinage: See chart… Dr. Millhuff: The psychotropic medication dose does not exceed the… Dr. Ellermeier: Maybe it's for… Dr. Millhuff: Dosages listed in the attached table or something like that. Dr. Ellermeier: I'm fine with that. I just don't want to delay the positive changes. Dr. Grinage: Right, but if we can get it done now; simple and it will be according to the chart so if you need to work on the chart that's great but you've got your criteria done referring to the chart. Dr. Mosier: Very good, so that would be then be the additional bullet point that you are adding there. Ms. Grant: …dosing limit on the following table? Or how do you want… Dr. Mosier: The attached table.	

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	Dr. Grinage: Charles said it good; how did you say that? Dr. Millhuff: The antipsychotic dose does not exceed the dosing limit listed in attached table. Dr. Grinage: For age appropriateness. It's written in all of them, so you don't really need that. Dr. Millhuff: Maximum dosage. Dr. Moeller: Does it need to say something about not approved? Ms. Grant: The drugs that are not approved at all. Dr. Ellermeier: Maybe it's the drug is listed? I don't know. Dr. Moeller: An approved or prescribing of approved, drug, anti-psychotic within the recommended… Dr. Millhuff: and is approved… Dr. Ellermeier: What if we still have on the table and there's a star and underneath it says not approved means drug will not be approved at any dose for the identified age range. Like have that as part of the chart rather than trying to put it in the criteria. Ms. Grant: I did add that. Dr. Grinage: You can change the chart to how you want it. I would if you are going to say something like that I would say requires appeal process rather than saying won't ever be approved. Dr. Mosier: Something to the effect of drugs listed as not approved have to go through the appeals process. Dr. Grinage: May require an appeals process. Dr. Mosier: May require an appeals process; something along those lines.	

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	Dr. Grinage: Will require. Dr. Mosier: Will require. Ms. Grant: Okay, what did you want the second bullet point to be please? After the dose does not exceed and you said how do we address the other ones? Dr. Ellermeier: Drugs listed as not approved for the age range will require an appeal. Dr. Grinage: So we said it on that table there was going to be no PA's they are either going to be not approved or there's going to be dose because the PA is something else. Am I correct? That is the only two categories is not approved or a dose limit. Dr. Ellermeier: I think so. Dr. Klingler: And then that's where we need to change to that table that we didn't do we need to change. Dr. Moeller: I didn't think we were clarified, I don't think we clarified the dosing. I don't think we voted it on the final approval but I think if we go back I think we're getting there. Dr. Adma: So will require appeal by written, will require written or verbal appeal right so it could be either one/or. Dr. Ellermeier: I think it falls to isn't there a defined appeals process? Dr. Zhou: There is a defined appeals process yeah. Dr. Klingler: So Dr. Mosier would it be appropriate to clean up this table by making a motion saying the ten to less than sixteen year olds we remove all the statements that requires PA and substitute not approved? Dr. Mosier: You can make that motion.	

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	Dr. Millhuff: Second. Dr. Mosier: All approve say 'Aye'. {Several 'Ayes' are heard} Dr. Mosier: Any opposed? {Silence} [Unknown. Many overlapping side conversations.] Dr. Mosier: I know there is some discussion going on about potential other changes so do you have any to discuss. Dr. Grinage: I'm sorry this is my understanding; this is discussion after the vote occurred so I don't know if it's part of protocol if you just want to move on. What I'm, what I thought we were doing was with regards to the with the regards to the dosing limitations was that there is a either you got appeal or they're within the doses. But I thought I was thinking there may be something in between process where there where there really another written form for a peer review process where you don't really go through the full appeal process. And I don't know if there's any difference in work related to those but there may be some conditions where we might feel like, like, you know, we don't we maybe need to explain ourselves but not go through a full appeal. Maybe there's no difference in that and we had talked about those different forms. Dr. Mosier: Yes, there was differences. Dr. Grinage: Those different ways of getting approval past the clinical PA that everyone goes through. Dr. Ellermeier: I think it, I think it would be easier if we see the PA criteria up because I think what we are saying is this document as a standalone goes away. The table alone moves over and that whole document is what we are talking about right?	

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	Dr. Millhuff: I think if I hear you right, it's what does not approved really mean? Does that mean one thing that we define when we say not approved does that mean it can go to an appeal or is it a peer review that utilizes this form that you can actually write something in. Dr. Klingler: I think from the clinical standpoint everyone would like to see a peer review not necessarily the full arduous process of an appeal. Dr. Mosier: And you're right, when we, when we discussed it earlier there was a PA process and there was an appeals process. The appeals process was associated with the not approved because the not approved was different from... Dr. Millhuff: Can we just say that not approved on this form means that it's a PA? Can we define it that way? Dr. Grinage: Well you've got to call it something else because everyone has including are totally different than the clinical PA because that's where confusion set in. They all meet the criteria under age for a PA but if it's not approved I don't know what you want to call that. Dr. Ellermeier: So maybe are you what if it's the antipsychotic? If the antipsychotic dose exceeds the dosing limit listed on the attached table or is listed as not approved, a peer to peer is required. Is that what we want? Dr. Zhou: Can I just explain the difference between a peer to peer and appeal to just make sure we're on the same level? What happens is after an initial denial of a PA the provider can call into the health plan and request a peer to peer to be held within three days and that's where you really schedule where both the provider and the medical director are free so they can discuss over the phone. Whereas an appeal they can also can call in within 30 days and request expedited appeal which will be reviewed within three days. In which you supply the information or you can say please refer to the information that was originally submitted or submit any additional information and that will be reviewed by a pharmacist and a medical director if the pharmacist does not approve it. So essentially the timelines are about the same we are looking at about 72 hour turnaround time if we're going the expedited appeal process so I just wanted to make sure everyone kind of is aware of what the process is.	

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	Dr. Klingler: What takes the least amount of time from the physician standpoint? Dr. Zhou: Honestly, that is really up to you. Would you prefer to call, kind of set up a time where you're free and the medical director is free? Or do you want to do a written peer to peer where it has also been brought up where you fill out a form saying that this is my reason for my request. You can do that as well or you can call in or have your staff call in for an appeal. All they have to do is do it over the phone or submit a form. Dr. Grinage: Can I then just clarify how I might understand this chart from what you said? So those that we've said are not approved require an appeal; those on here that say require a PA should probably be a peer review and those that exceed a dose limit would be like a handwritten something that you can go through and you don't have to the full PA again? We talked about if it's already been approved one way but you want to exceed the dosing you address the dosing issue. Is that kind of how I am understanding that? Dr. Friedebach: Well in my mind I think it kind of it gets back to that essential question of if you exceed the dose limit, do you want a reviewer to look at a written statement and say yes that makes sense. That kind of gets back to Nicole I think you said… I think we don't want them to go beyond this… the other… so, I mean, I think that's the essential question. Do you want a provider to say this patient has just recently been in the hospital; I've tried multiple different antipsychotics this is the only thing that works this is the way to avoid multiple concurrent antipsychotics do you want them to put a justification to exceed this limit, and for our reviewers to say okay, then there has to be some criteria there for guidance; and if you say, you know, I really don't want them to write anything I want this to be a discussion; I want this to be a more thorough review, then you leave it as it is. And then they go down the process and to Angie's point the idea of a peer to peer versus an appeal is really driven by the provider. The provider is the one who decides I want to talk or I would rather just send you my thoughts and evidence and they can do either one once they get the denial. But I think if you want something that allows a provider to skip this dosing limit without doing those two things that's where you have to put some of those things in. And to Nicole's point and I think Dr. Millhuff, you were there too in some ways maybe that's not an appropriate given the dosing limit because you say nope, this is a strong dosing limit and we don't want extenuating circumstances, we want that to be a higher level discussion. So I think once you make that decision as a committee if you make the decision that you don't want them to exceed with a conversation or	

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	a thorough review, you have what you want right now. But I think if you want extenuating circumstances, you can put a couple of those examples in there. Dr. Grinage: So to get through the criteria where we are established right now with the criteria is that if is not approved then that is just a written appeal. That is kind of what we have set for the criteria purpose. Dr. Friedebach: Right and I think you guys sound like you are pretty comfortable there. Dr. Grinage: So my thinking was if the appeal was much more difficult than a peer review. But it sounds like a peer review is more time consuming. Dr. Friedebach: It just depends on the provider's perspective. So some providers may, instead of bringing it all together or directing their staff to bring it all together, they may say 'schedule me a time', I and talk a lot easier than I can bring this together. Dr. Grinage: See, for a guy that never does this, that answered it. I need a 'yes' or 'no'. Dr. Friedebach: So one doc may say 'I want to talk to you.' and the next doc may say 'my gosh, I don't have time to talk to you. My chart speaks for itself. Look at my chart for goodness sakes.' Dr. Porter: I would want to say that again, as a Kansas tax payer, that if you opt for the option where you've taken a half hour off your schedule, where you're getting paid by the State or County and you'd rather do that and leave a patient without an appointment as opposed to send in a form, I think you should rethink that. I think we should always try, because you have a 'no show' that day. Unfortunately we have 'no shows' in our clinic. You can fill out a form on this appeal and not you know, you know, deny a patient a slot and use up money of your salary to talk to a doctor as your first line. So I'm, I know, I think I'm a bit repetitive, but I really think at least the first crack at writing your explanation out, hopefully it's reviewed by somebody who knows what they're doing, and then you're good. If they want to deny it, and you want to talk to them in person, then you have that option. Dr. Mack: Currently on the appeals, I get a pretty even mix. I get, sometimes, just a copy of notes with the appeal. Sometimes I get a written explanation. And sometimes it's you know, it's really	

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	brief, a couple of sentences. But it usually suffices. Because sometimes I get a much longer, often times, it's just a few sentences. Sometimes I get a request for a phone call. Dr. Grinage: I'm comfortable with that on the criteria. I was just thinking an appeal, from the forensic world, briefs and briefs, and all sorts of things. Dr. Mack: As long as it answers the question 'Why?', 'Why did you prescribe this medication with this dose?', it doesn't have to be, you know, *War and Peace* just as long as it answers the question. Dr. Grinage: Okay. Dr. Mack: It can be a phone call; it can be written; it can be anything. Dr. Moeller: I understand the 'not approved' column wording, what if they go about, they have a dose and they go above the dose? Is that not approved or peer to peer? Dr. Ellermeier: I think we're treating them the same. I don't think we've come to a consensus on how it should be. Dr. Klingler: One of the things I think I'm hearing you say is that what we need to do is outline the special circumstances and you're saying that special consideration, or some other verbiage, would be given to the patient just dismissed from the hospital or if the patient in 'this situation' or 'this situation'. In what situations, realizing we wouldn't be able to define all of them, do we need to specify that you know, exceptions should definitely be made for 'this' and 'this'? Is that where you were going? Dr. Friedebach: I think, I hear there being disparity in the committee's perspective on it. And I think that if the idea is the dosing direction stand on their own and we want that dosing direction to make it inconvenient to exceed that dose, then, for good reason, and to take a moments pause, then again I think you have what you want. I think if you want to have the extenuating circumstances lined out; you can put that in there, but again, it takes some of the muscle out of your dosing, and so it makes it more grey. So I really think it's committee's perspective. It sounds like there's quite a bit of comfort around the idea of this dosage and I'm going to look at you in large part, is really going to isolate the very few individuals that probably should take a moments pause on.	

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	Dr. Millhuff: I would say, to provide some perspective as a child psychiatrist, I'm not getting anywhere near many of these max doses. So I think we are in good range. I mean if someone has a problem with these dosing limits, they're probably practicing in a, a dangerous way. Dr. Porter: I think the one, I guess, I said earlier, the one no brainer, is we don't want this to happen at the pharmacy window, outside, leaving a hospital. I don't think. The dose may need to be lowered, but it doesn't need to be stopped if they've just been stabilized in the hospital. So that, I think, is not a whole bunch of criteria. I think we should put in that if a person has just left the hospital at 'this' dosage it should be approved for back to the 60 days. I think 3 doesn't do anything. That what I would, that's my two cents. I think everything else, if you need to justify it, let somebody review it. Dr. Grinage: Make that part of the main criteria? Dr. Porter: I would. Dr. Moeller: What if the hospital dosed it wrong? Dr. Porter: Well then we, if the hospital, when they came in the hospital, they met criteria for admission, and when they left, they met criteria to be discharge let's hope. Dr. Moeller: What if it was a dosing error on their prescription and they wrote an extra zero? Dr. Millhuff: What if in the written response you just said 'this is the hospital dose, to stop it means probably this patient will be back in the hospital'. If you were reviewing that, you would probably say 'let's approve it'. Dr. Friedebach: I think that kind of gets back to this form, too, the ability to put that in there. And the 60 day override, hopefully, and the 5 day override with prescriptions at the pharmacy. Hopefully we have a number of safe guards that would be in place. Dr. Moeller: With the 60 day override, do we need to have anything for the hospital? Am I misunderstanding?	

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	Dr. Porter: No. Not if that never happened. But it does happen that people are, you know they go, and they're told they can't fill it because there's a prior auth on it. As long as that's in place, I've go no problem with it. As long as they cna get 60 days before their medicines are stopped coming out of the hospital. Dr. Moeller: Well, with how we've written it now, is that appropriate? Because we do have a 60 day in the criteria. Ms. Grant: I guess I'd like to ask the MCOs, are you getting calls; and are you overriding for 60 days? Dr. Zhou: Yes. Ms. Grant: This does come through? This is happening? Dr. Zhou: This happens today. Ms. Grant: But Dr. Porter's saying that it's not, so I guess that's where I'd like to clarify. Dr. Porter: I want to clarify that in my comments, sometimes it's hard for me to keep in mind which 3rd party payer is involved in the situation. So if it doesn't happen on a Medicaid case that a person comes out of the hospital on a dose outside of agreed upon, that they're told that they can't get it? Then I'm basically need to not keep talking about it. Ms. Grant: I want to make sure we address our part in that piece. Ms. Cobb: What is the difference between the five and sixty days that you all are talking about? Dr. Murff: 60 days is just for the antipsychotics in children. Ms. Cobb: Okay. And the five day is? Dr. Murff: That's the only time we allow 60 days. But for all others, here at United, we have a five-	

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	day override to allow time for the prior auth. Dr. Todd: You mean like ADHD meds? And other mental health drugs? Dr. Murff: Right, and other drugs that have a prior auth. Dr. Millhuff: You have a five-day override that's been in effect? Dr. Murff: Yes, five day, per the drug and strength per that individual per 365 days. So if there's a prior auth, then the pharmacy receives instructions on how to do a five day override. Ms. Grant: Jennifer, are you talking about what we talked about earlier? Dr. Murff: Everything except for the… So for the antipsychotics in children, that has a sixty day override and that's written into the prior auth. Then for all other drugs that have a prior auth, there's a five-day override. Dr. Millhuff: All other drugs that aren't antipsychotics? Dr. Murff: Correct. And well antipsychotics in children that's the only one that has the sixty days. For the antipsychotics for the multiple concurrent or the antipsychotic dosing limits in adults, those don't have a sixty day override. Dr. Millhuff: What if we have all these grandfathered people coming off of that here pretty soon? That we all grandfathered in the beginning? If they're at the pharmacy and need their medicine on a Friday afternoon, the clinic's closed, what are you going to do when they say 'I need my 30mg of Abilify.' Do you have this five-day thing that Annette was talking about earlier? Dr. Murff: The five-day override would work for even for someone that's been grandfathered. Because the five-day override is a code that the pharmacy actually puts in and the grandfather is something that we put in. Ms. Grant: And Jennifer, currently right now it's three days.	

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	Dr. Murff: At United we just do the five days. From the get go. Ms. Grant: Oh you do five days, okay, I was just going to make sure that everybody gets five. Dr. Millhuff: Then there comes the practice that people are actually using that. Dr. Mosier: Just to go back to the 'not approved' and then the 'requires PA' where we've changed everything to 'not approved', it seems to me that even though we're trying to make that distinction between 'requires PA', that it could all be PA. It's kind of a distinction that we've made. So if we say 'not approved' we could do, still do it as a PA-a written or a verbal PA going forward. Is there any reason 'not approved' couldn't just mean what it means for the others which is going through the PA process? Dr. Friedebach: I think the 'not approved' maybe communicates to our reviewers that this is probably clinically inappropriate in most circumstances. Is the only thing I would think of with the 'not approved'. It's a little bit, and maybe you mean that for all the, not PA, but the 'not approved' I think our reviewers is probably going to read that it would be acceptable in very atypical situations. We are trying to send a message that this is not typically appropriate in this age group. Am I right about that? Is that the committees intention? Dr. Grinage: What you just said kind of confused me. I thought the PA process, everybody has already been approved because it's a clinical PA and so it's a separate process inside that clinical PA that may or may not be approved. But you're calling that a PA as well. So, that's where, to me, it gets confusing. Dr. Moeller: There's two PAs and I think that's where we keep getting, yes there's two PA's and I think that's where we keeping getting confused. Dr. Ellermeier: But I thought we were moving towards combining them. So I think it would be helpful if we move this table to the other one so that we can see it all together. This as a stand-alone document, I think we're getting…I thought we already made that decision. Dr. Porter: The only catch is what Dr. Mosier brought up, is that, is within this table we have those two words still.	

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	Dr. Ellermeier: Yes, but I think we need to address it on the other criteria, not on this as a stand-alone. Dr. Moeller: So this procedure is going to go away? Dr. Mosier: The table will become an attachment to the other criteria. Ms. Grant: So we'll go back to that criteria and discuss criteria and assume that the table will be attached as part of this criteria. Dr. Klingler: So it's a question of nomenclature. 'PA required' might not be the right nomenclature. 'Not Approved' is not the right nomenclature. What do we need to substitute in for those two words to be more clear for what our meaning is? Ms. Grant: Requires review? Dr. Klingler: Yeah, I think that's what we need. I think the concept, we're headed in the right direction. I don't think we verbalized it well in that table. Dr. Grinage: Requires review? I don't even think you're going to need that one. Drugs listed requires review as 'requires review' is a bit redundant. Dr. Adma: I like that better than 'not approved'. Dr. Klingler: I think that conveys to the reviewer more what our intention is. Is that those situations need to be looked at for appropriateness. Not axed. Dr. Zhou: But I thought Dr. Millhuff was saying that, you know, none of these doses exceeding the limit should really be appropriate. Therefore we shouldn't even allow it on the first review. They need to go through an appeal process where they talk or submit documents to the medical director. Dr. Adma: Which is okay.	

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	Dr. Klingler: That would still happen. Dr. Mosier: Let's see if we can conceptualize it this way. Prior auth has a keyword in it, prior. So it's like you are looking ahead and you're saying 'okay, you want to get this authorized before it gets dispensed'. And another way you can say 'not approved' is an automatic denial. If you look at it that way, it goes through the appeals process. That can be expedited or not. So I think, technically, that is probably the distinction we are making in the denial is because we don't think it should happen, except in very rare cases as opposed to the prior auth, it's something that we think will happen on a more routine basis but we do want to take a look at it further. If it either exceeds a dose or, in certain cases, it's a long acting medication in this age range. We think that needs to be looked at carefully. Would be a good distinction to make. Does that clarify? Dr. Ellermeier: So I, what do we want to happen? I'm still unclear if we all agreed on what should happen if the dose is above that limit, currently it says 'not approved' but we can change that nomenclature. If it's one of those two things, what happens? Is it a peer-to-peer or is it a denial and an appeal? Dr. Friedebach: I would say it would be a denial. Then you're on the same path of every other denial where the provider has two options. Peer-to-peer or appeal or both. I mean if they, the reality is, if you get the denial, the provider says I want a peer-to-peer and that peer-to-peer ends with we still don't see eye to eye, they still have the appeal rights. So, I mean, by saying if we feel like this is a good dosing limit, the action would be a denial to exceed it and then that provider has peer-to-peer or appeal. Dr. Zhou: And then the provider may actually decide maybe I should lower my dose rather than pursuing an appeal. There they have another decision point as well. Do I really think this is appropriate? If so then move it forward, if not, I'll just lower the dose. Dr. Klingler: Do we have any data on how many times in the last month-two months that this would have been triggered? Ms. Grant: So, you're wanting to know how many children of certain ages are on these medicines. Is that what you're asking?	

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	Dr. Klingler: Within those limits or denials. I mean, if it's ten kids in the State it would be a whole lot different than 200 kids every month. Ms. Grant: We do not have, well, let me show you. We didn't have dosing, we never approved the dosing range yet, so we couldn't do a study to see that. Dr. Todd: But you could see how many kids are getting antipsychotics in the age ranges. Ms. Grant: Yes, do you want to see that? {several people say 'we've got it'} Dr. Klingler: I was just wondering how many of the kids listed on here would be affected by the policy we're enacting. You know because what, we want safety for the kids but we also know we have a burden in the mental health system. And we want to protect the time of our providers. And so I think we've got to look at, if we don't have the providers as Ty's gotten to, then we also don't have safe mental health. So we have to look at the pharmacology. But at the availability, too. I think that's where the question comes in as to the process. If we're taking away multiple appointments from our providers, we've added in another consequence to our mental health system. Dr. Grinage: So for criteria purposes, if she puts up there 'drugs listed as not approved for the age range will require appeal', do we need to say peer review or appeal or is appeal okay when it comes to it, or one or the other? Dr. Todd: So the PA would just be denied. And then the provider automatically has that choice on their own. We would not have to spell it out. Dr. Grinage: What do we call it in the criteria? If we say an appeal could mean either one, written or peer-to-peer. Technically speaking for the criteria. Dr. Todd: You could put a note in here, under the criteria, and say, you know, for doses listed as not approved, or whatever language you want to use, the PA will be denied but may be considered for approval upon appeal or peer-to-peer. Does that work?	

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	Dr. Grinage: So I would say, I'm talking about the criteria, for those that are not approved need either peer review or appeal. I'm just saying we're trying to get through the wording for the criteria. Dr. Porter: A different payer recently had a difficult time finding the appeal process. Eventually found, took a long time to find how to appeal. So I think that would be useful if we're going to leave that what to do, a link, phone number, or some way to get to the appeal process. Dr. Ellermeier: Isn't that in the denial letter? Dr. Todd: It is. On every denial letter that we send out, I believe it's a requirement for all three MCOs. And then when we send you the letter to say that the PA has been denied, if you scroll, that's why those letters are really thick, becaue if you scroll down into the letter, flip to the back, it talks about appeal rights, contact numbers, and how you go about to do that. Dr. Klingler: So, Lisa, I'm confused. Someone writes something that exceeds the dose limits; they're going to have to do a PA, which takes a while. Then they have to do this next step of peer-to-peer or will it just automatically get denied at the pharmacy, skip the PA step and then go to the peer-to-peer or appeal? Dr. Todd: Okay, so, so if we kind of step through how a claim would come in. So the provider, the patient is discharged from the hospital. The doctor had called ahead, you know, sent in the prescription. The pharmacy went to fill it. It's going to deny-PA required because the patient is 13 years of age and it's an antipsychotic. So, then at that point, the pharmacy would tell the member, you should call the provider and say by the way the drug denied. It requires a PA. So that's when the provider's office or the hospital or whomever would have to start that PA process. So that's when they would download that form or they could call in. Walk through all the questions, all these questions that you are talking about all these criteria. Would get to the dosing piece also. If everything, all the check boxes are where they need to be to meet the criteria, then the PA would, technically, be approved. Then the pharmacy would then at that point, ok the PA is approved, so they could go ahead and re-submit the claim that they already had. You know, based off of that prescription and the claim would pay and the member gets the med. Does that kind of answer your question?	

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	Dr. Klingler: Then what if it's over the dosing limit? Dr. Todd: If it's over the dosing limit, that's part of the questions. As far as, you know, the member must meet a, b, c, and the dose is within this range. So, if it's you know like 20mg, the provider would say, yes, this is a 10mg Abilify and they've met a, b, and c, then the MCO would approve that PA and the PA would go through. If it's greater than, and I'm just making up doses, if it was greater than the 20mg or whatever dose that we, the board had set, then the PA would be denied. That's when, then the pharmacist could or the provider could say, this is when for these antipsychotics, let's go ahead and use our 60-day override, get the member their med while we can take the time and we can decide, as a provider, this member is going to be needing this ongoing, but that would give the member time to either go to their regular provider as opposed to the hospital provider or you know, whatever scenario that is, to try to work that out. Decide if the dose needs to be changed or you know, any of those little nuances that we've been talking about. Dr. Klingler: That helps a great deal, thank you for that. Dr. Millhuff: If the patient is a foster care child that's been placed in a remote area and the only thing that doesn't get checked is the credentials of the provider, let's say they're not a psychiatrist, but they're the only one there to look after them, I guess that would be an obvious example of if everything else was there, I wouldn't want that kid to lose their medicine. Just add to that I mean because some of the feedback I'm hearing, is how hard you want us to set these limits with people and hopefully then if Dr. Shoyinka or someone there on the phone and look at it and realize oh ok I understand the situation and I will approve this for you. It is a lot of different scenarios here I think that we have to kind of… anyway. Dr. Mosier: I think a couple of things that I kind of wanted to go to, one is kind of this whether or not because there is a discussion of whether or not this what we had originally with requires PA versus not approved and from what I understand they're not approved from your perspective when people are reviewing it, it makes a difference, because I was proposing you know or asking since what we changed makes them all look the same, not approved. But then and that's where I'm saying that just kind of means they could just go to the PA process; make them all the same. But from the perspective of the managed care organization are you wanting to distinguish the PA process and the hearing process? Do you see what I'm asking?	

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	Dr. Todd: Not really; could you try to ask again. Dr. Mosier: Well what I'm let me ask it in another way. So if somebody has are these ones that are not approved we had a distinction requires PA and not approved but if you fill out a one of our PA forms which would be very quick and easy to do and then you send it in. So if it's not approved technically it is denied but then after you go through that next step if it's going to be now you can do a written appeal or a peer to peer does that same form become your written appeal or is there something else you have to do with it in the appeal process? Dr. Friedebach: You can you can appeal through whatever form you want to whether that's by phone call or written and so using this form is helpful to do the appeal I don't think there is any problem in doing that. I think one of the things that might get us to a better comfort level is to go through here and think are there any of these that are not approved that we don't feel fit into that criteria where we feel comfortable saying these shouldn't be approved. Because we did not have not approved and needs PA but it seems to me that all the not approved everybody's comfortable with those being outliers. Is that the case? Dr. Mosier: If we agree with that then we're good with where we are. Dr. Friedebach: Then I think we are good and we are being accomplished and if there's one among these we say that is a little restrictive and probably doesn't reflect the standard of care across the State of Kansas maybe then we look at a dose there instead of not approved and just make it real crisp that when we say not approved we really mean this is inappropriate in most circumstances. Dr. Zhou: You can always default to the max dose as well if it was PA required. If you feel like that sometimes it could be appropriate but we still default to the max that you already have as an upper limit. Dr. Porter: I'm still having a hard time figuring out we are changing all of the injectables to not approved; what's left that says prior auth on here? Dr. Ellermeier: Nothing.	

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	Dr. Porter: Okay. Dr. Klingler: My point was how do you prior auth something if we haven't set a dosage level at it? Dr. Mosier: We are prior authing anything that is above the dose limits that we have set. Dr. Klingler: But, we have a bunch of them that didn't have dose limits on them that said prior auth. Dr. Porter: But we got all of those off. Dr. Klingler: That was my point of taking the prior auth off was how do you prior auth something if you don't give the dose limit on it? Dr. Mosier: How about if we have Annette recap, top to bottom, where we are. Ms. Grant: Okay. Dr. Mosier: Taking it from the top and actually starting with the, I would actually start with the clinical criteria because this will be considered an attachment of the, the dosing limits, would be an attachment of the clinical criteria. Ms. Grant: Okay, so, top to bottom for PA's for antipsychotics in children and adolescents less than 18 years of age, which was a title change. Going down to the first set of criteria for children less than 4 years of age, added a PTSD with associated severe agitation. Changed the DSM-5 diagnosis to or the most updated diagnosis. The next bullet point is the non-psychopharmacological interventions. Dr. Millhuff: Annette the most updated edition diagnosis is…. We are referencing… Ms. Grant: Oh, okay, and updated edition put in parenthesis or most updated addition. Dr. Porter: Most updated DSM?	

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	Dr. Mosier: Edition. Ms. Grant: Okay. Most updated edition of DSM. And then… then the non-psychopharmacological interventions-updated the 'indicated'. And this next bullet point we added the antipsychotic dose does not exceed the dose limit listed on the attached table. Now we have some verbiage that might change the next bullet point. So how are we addressing the drugs listed as not approved? Require review? Require? Dr. Grinage: I think we decided to leave it as not approved. Dr. Porter: And require an appeal. Dr. Moeller: In the denial it requires appeal. Ms. Grant: Drugs listed on the table as not approved for the age range… Dr. Ellermeier: Will be denied? {Many people speaking at the same time} Dr. Mosier: I think we should go with what we had, 'requires appeal'. It tells you what the action is. We'll go with 'requires appeal'. Dr. Grinage: That's what I was asking, review over appeal. {Many people speaking at the same time} Dr. Mosier: Appeal or requires peer review. Dr. Grinage: That's kind of what I was asking. They can use two different processes? Dr. Porter: Appeals are going to go to a peer. Dr. Friedebach: They can lie on top of each other. A provider has the right to both.	

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	Dr. Grinage: Technically, how do we word it just for criteria? {Many people speaking at the same time} Dr. Adma: Requires appeals. Dr. Grinage: Appeals, okay. I just didn't know if it led to a peer review or not. Dr. Ellermeier: I think the way it is-is fine. Dr. Todd: I think so too. Ms. Grant: Requires an appeal. {'Okays' are heard} Ms. Grant: Alright, so next addition was to make sure we had the one-time 60 day override for this criteria for this age of less than 4 years. So, going on to 4 to less than 6 years: again the addition of PTSD with associated severe agitation, updated the DSM-5 or most recent edition. And then for the next bullet point, the non-psychopharmacological interventions-updated 'indicated'. And then the two additional bullet points: 'The antipsychotic dose does not exceed the dosing limit listed on the attached table.' and 'Drugs listed on the table as not approved for the age range, requires an appeal.' For ages 6 to under 18 years: addition of PTSD with associated severe agitation; the DSM-5, or the most updated edition; And then the two additional bullet points: 'The antipsychotic dose does not exceed the dosing limit listed on the attached table.' and 'Drugs listed on the table as not approved for the age range, requires an appeal.' And the addition of the table. I believe now there's no 'requires PA'. Everything without a dose has 'not approved'. Dr. Ellermeier: I think you can remove the stars because they are accounted for in the criteria. Ms. Grant: Okay. Dr. Millhuff: May I make a comment?	

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	Ms. Grant: Yes. Dr. Millhuff: Okay. When I look at the minutes for when these original atypical? antipsychotic criteria were approved in October a couple years ago, there was discussion about the lab work and other parameters to be attested to; that you attempted to get that. Now, we are again not putting that wording in here, yet we are required to call all that in. It's required, but we will be denied the medicine now if we have a patient that didn't follow through with the lab work. So, the point is… Ms. Grant: It says right here… {Several people talk at once} Dr. Millhuff: …oh that's sufficient enough. I just want to make for sure, for sure, that's there. Okay. Dr. Mosier: Yes, it is. Ms. Grant: Is there anything else on the charts that you see that needs attention? Dr. Mosier: Could you just go to the top and read from there? Ms. Grant: Okay, *Aripiprazole*: for 4 to less than 6 years maximum dose 15mg; 6 to 10 years 20mg and 10 to 16 years 30mg; Leaving the adult dose on there as 45mg adult max. *Aripiprazole Maintena*: not approved for ages 4 to less than 10 years and actually for under 16 years all of them not approved. With the adult dose 400mg for 28 days. *Aripiprazole Aristada*: not approved for any ages except for adult 882mg for 28 days. *Asenapine or Saphris*: not approved for less than 4 or 4 to less than 6; 10mg for 6 to less than 10; and 20mgs for 10 to less than 16; same dose as the adult. *Rexulti*: not approved for anyone less than adult. And *Vraylar*: not approved for any age less than adult. *Chlorpromazine*: maximum 40mg for 4 to 6; 200mg for 6 to less than 10; and 800mg for 10 to less than 16. The adult dose-1500mg. *Clozapine*: not approved for 4 to less than 6; 300mg for 6 to less than 10; 600mg for 10 to less than	

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	16; and the adult max is 900mg. *Fluphenazine*: not approved for 4 to less than 6; 5mg for 6 to less than 10; 10mg for 10 to less than 16; with the adult max of 60mg. *Fluphenazine [HCL and Decanoate]*: not approved for any of the children ages; 100mg for adult. *Haloperidol*: max 6mg or 0.15mg per kilogram per day the lesser of and just to make sure on the MCOs is that ok on that, as far as, I guess we just put the max 6 and that would be your limit ok. Then same 6mg max for the 10 to less than 16 or 6 to less than 10; 15mg for 10 to less than 16; and 60mg for the adults. *Haloperidol Decanoate*: not approved for any ages other than adult 500mg per 21 days. *Fanapt*: not approved for 4 to less than 6; 12mg for the 6 to less than 10; 24mg for 10 to less than 16; same as the adult dose. *Loxapine*: not approved for 4 less than 6; for 6 less than 10 30mg; 10 to less than 16 60mg and 250mg for the adult. *Latuda*: not approved for 4 to less than 6; for 6 to less than 10 it is 80mg; 10 to less than 16 is 120mg; and 160mg is the adult dose. *Olanzapine* the *Zyprexa Zydis*: not approved for 4 to less than 6; 12.5mg for 6 to less than 10; 20mg for 10 to less than 16; 40mg is the adult dose. *Olanzapine Relprevv*: not approved for any age but adult 300mg for 14 days. Then *Olanzapine/Fluoxetine* combination *Symbyax*: not approved for 4 to less than 6; 6 to less than 10; and then it is Olanzapine-12mg/Fluoxetine-50mg per day for 10 to less than 16; and the adult Olanzapine-18mg/Fluoxetine-75mg per day for adults. *Invega*: not approved for 4 to less than 6; for 6 to less than 10 it is 6mg; 10 to less than 16 is 12mg; same as the adults. *Paliperidone palmitate*: not approved for any age but adults; 234 per 21 days. The long acting *[Paliperidone palmitate] Trinza*: is not approved for any age but adults; 819mg for 84 days. *Perphenazine*: not approved for 4 to less than 6; 12mg for 6 to less than 10; and 22mg for 10 to less than 16; the adult dose is 64mg. *Orap*: not approved for 4 to less than 6; the 6 to less than 10 has a 6mg max; the 10 to less than 16 has a 10mg max; with a 20mg max for adults. *Seroquel*: not approved for 4 to less than 6; the 6 to less than 10 is 400mg; 800mg for 10 to less than 16; and the adult dose being 1200mg. That is the same as with the XR as well. *Risperidone*: max dose is 1.5mg per day for 4 to less than 6; 4mg for 6 to less than 10; and 6mg for 10 to less than 16; the adult dose of 16mg.	

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	Risperidone Consta: not approved for any age but adults of 50mg for 14 days. *Thioridazine*: not approved for any age but adults 800mg. *Thiothixene*: not approved for 4 to less than 6; and 6 to less than 10; 10 to less than 16 is 15mg per day; the adult dose max of 60mg. *Trifluoperazine*: not approved for 4 to less than 6; 15mg per day for 6 to less than 10; 10 to less than 16 is 40mg per day; same as the adult max dose. The last one *Geodon* not approved for 4 to less than 6; 6 to less than 10 is 80mg; 10 to less than 16 is 160mg with the adult max of 240mg. Dr. Ellermeier: Do you need a motion? Dr. Adma: Before we go through a motion one quick question. So for a kid who is 5 years of age and is needing to be placed on an antipsychotic medication the only two options that I see here either Risperdal or Thorazine according to this. They cannot get, unless it requires prior authorization and an appeals process. You cannot put a 5 year old on Zyprexa, Seroquel or Geodon which have been around in the market for a long enough time if they are allergic to Risperdal. Dr. Grinage: What is that? Dr. Moeller: Abilify. Dr. Adma: Abilify up to 15mg, you're right. Ms. Grant: And I think that was the Texas document recommendation is where we got that from. Dr. Adma: Chip, are you ok with that? If you using Risperdal and we are saying don't use Zyprexa at all and by the way once they are 16 we are using 12.5 Zyprexa. Dr. Moeller: Those are the two that I'm familiar with that have sufficient evidence you know under 6 years old and I think that is what was written in the Texas. Correct? Dr. Millhuff: So yes a 5 ½ year old only has Risperdal… or Chlorpromazine. I am personally ok with that. There could always be an exception. You also got to consider that child psychiatry is still in this gold cards status so you know you've got a really tough to treat kid you wouldn't want to	

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	use Zyprexa we're not going to be able to use that anyways. Right? Ok. Now that's my opinion; what, what.. are you? Dr. Adma: I'm again we are limiting the choices with this. I just want everybody to be aware of that. I know that we have, we have choices. Dr. Grinage: I would also add on we have criteria for prior authorization for antipsychotics prescribed less than 4 years old which to me as a forensics guy seems kind of crazy, but I'm sure it happens, but we don't, there's nothing in the chart under 4 so I guess I would recommend we probably need to address that but for the sake of putting some closure on until/if this issue is addressed. Dr. Porter: I think in a way the silence on the column speaks that we don't even want to really don't want to see it. Maybe it should say… Dr. Grinage: But there's no guidance values on there. {they speak over each other} Dr. Grinage: Again, I couldn't even speak even come close to speaking to it. I don't do that kind of work. But it's just a discrepancy. Dr. Mosier: I had noticed that too; that we didn't have that on the table and so we actually had added the language to say the antipsychotic dose does not exceed the dosing limit listed on the attached table and the appeal and we don't have anything for us to enforce so maybe the words we say that. Dr. Porter: Less than 4 needs to be appealed also. Dr. Mosier: Yes just that it always needs to be appealed for less than 4 years. Dr. Grinage: I didn't know whether that was prudent or to clump it into the 4 to 6 year and I don't know. I have no clinical experience in this. I would defer to the expert here.	

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	Dr. Millhuff: My brain is full. Does it really matter if we're, if you're a child psychiatrist or a behavioral related; a super crazy out of control autistic child. Dr. Grinage: They all need to get looked at no matter what. At that age it needs to be discussed. Dr. Millhuff: So the gold card status would not be applied in that scenario is that what we're saying? If I have a 3-year-old who's, who I want to put on an antipsychotic. Dr. Mosier: The gold card applies unless you specifically say it, it has to be called out in the policy to say gold card does not apply on this policy so in this case it does apply. Dr. Millhuff: It does apply is what I am concerned about. Dr. Mosier: So because of that and we didn't address it on the table changing that less than 4 to say it should say drugs listed on the tables. Ms. Grant: Drugs listed on table 1 are not approved for this age range? Dr. Ellermeier: So what are approved? Dr. Mosier: It's not on the table; that's the point. Dr. Millhuff: So maybe… Dr. Mosier: The point is it's not on the table so we should say drugs are not approved. Dr. Grinage: Antipsychotic medications are not approved for this age. Dr. Mosier: Age range and therefore require an appeal? Dr. Grinage: Would require an appeal. Dr. Ellermeier: Why do we have all the criteria?	

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	Dr. Millhuff: What if we just take… Dr. Grinage: That's a good point. {several people trying to talk over each other} Dr. Mosier: If it meets the appeal then you have to look at criteria. Dr. Millhuff: I was going to say if it has to be prescribed by only specialists who are already gold carded then I think we can just take out 'drugs listed on table 1 are not approved for this age'. Take that out. Dr. Ellermeier: Should we make the table then should the table be just less than 6 and take the bottom out of it? So anyone less than 6 is that first column. Dr. Porter: You still have 3 approved drugs in the 4 to 6 that would be different in below 4. Dr. Ellermeier: Yeah because if you don't, if you just, then, what you are saying is less than 4 can get anything but once you hit your 4th birthday you can only pick one of these 3. Dr. Millhuff: I think that I would say that probably, I can't say for everyone, I can only say for the, well I don't know, I mean what if you have a psychiatrist a general psychiatrist that is choosing to press on. I will tell you that the only meds I am going to use are Abilify or Risperdal period and so that would apply to this 4 to 6 age range. I'm not, I'm not going to use anything else because that's, the data is; those are the only two meds we have any data that is close to supporting the use of that medicine if in some exceptional case of [inaudible]. Dr. Grinage: Do you ever use [inaudible]? Dr. Millhuff: I have had severe autistic kids that I have diagnosed. Dr. Grinage: Then I would just remove the bottom half. Dr. Moeller: You're talking about 3 year olds. Because the criteria is 4 to 6 so just say less than 6.	

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	Dr. Ellermeier: Yes, I think we change the table to less than 6 and add the two bullets back in. Dr. Friedebach: Would that be good? It's clear direction. Dr. Todd: Otherwise it will go to the adult max dose. Yeah. If you don't specify. It's already… Dr. Millhuff: Great. While they are talking I just want to make a quick comment since we got 13 to 18 year olds coming into this set of criteria is there any discussion about grandfathering that maybe that pretty large group of kids, like we did initially with the less than 13? Ms. Grant: Dr. Millhuff, I have to say it is almost 5 and this building is supposed to close at 5 so. Dr. Millhuff: Yeah, I just wanted to get that comment in. Dr. Mosier: Do we have a motion? Dr. Ellermeier: I didn't catch what your comment was? Dr. Adma: Motion to approve the policy as listed on the screen with all the changes. Dr. Porter: Second. Dr. Mosier: All in favor 'Aye'? {Several 'Ayes' are heard} Dr. Mosier: Any opposed? {Silence} Dr. Mosier: Okay, thank you very much.	
III. New Business A. Prior	**Clinical Public Comment: -** No requests were received.	Tabled

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Authorization 1. Benzodiazepine Dosing Limits	**Committee Discussion:**	
IV. Open Public Comment*	**Clinical Public Comment:** - No requests were received. **Committee Discussion:** None.	
V. Adjourn	**Committee Discussion:** None. Dr. Mosier: Very good work today and we will pick up where we left off next time.	Dr. Mosier ended the meeting at 4:57pm.
*Clinical and open public comment requests and written testimony must be submitted one week prior to meeting to Annette.Grant@ks.gov. If providing clinical comment, please indicate which agenda item you are requesting time to comment. Time limits during period of comment will be determined based on number of requests received. The next MHMAC meeting is scheduled for August 8, 2017.		